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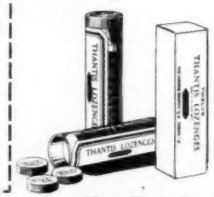

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—Courtesy of City Art Museum, St. Louis

CHRISTMAS 1951

Hear the merry bells ring out
Over all our blessed land.
Love shines on all of us
In this holy season.
Daily tasks grow lighter
As men draw together in
Yuletide's cheering warmth.

Cherish every friend whom
Holiday time brings closer.
Everywhere is hope again, peace on
Earth, good will to men . . .
Ring out, oh bells of Christmas cheer!

For all of us throughout the world
Reach out to brothers far and near, and
Open wide our hearts to the
Mysteries of Christmastide.

Now comes the time of gladness,
Oh, joyous, joyous season!
Pray let us share with others
Health, happiness, and reason.
Now and for all time.

Children and War

JANE BRUNNER McMACKIN, R.N.

BECAUSE FAMILIES consist of people and because war, especially in the modern totalitarian form, affects most people there is scarcely any aspect of family life which does not come within the range of repercussions. Considered sociologically, war is a complex of comprehensive changes involving the reorganization of the entire societal pattern. Since the family is part of organic civilization family changes in wartime are inevitable.

Modern war disturbs the settled habits of millions, greatly extends their social contacts, and, by separating family members, interferes with intercommunication by which family unity is maintained and promoted. It is clear that war has immediate impacts upon many phases of child life. Situations occur in spite of careful plans for their prevention. Only time will tell the total effects upon the child.

In the early months of American participation in World War II fear was expressed for the physical security of the children. Fortunately these fears of physical violence to the children of America never materialized, as they did for the children of virtually every other belligerent nation. It would be fatuous to compare the personal and family adjustments faced by American children with the starvation, bombings, and utter personal disorganization experienced by the children of the other warring nations. Nevertheless the rapidity of social change in wartime America, coupled with the long periods of deprivation of the father, left psychological scars on the personalities of many children. The family was subjected to diverse stresses and strains, some merely the accentuation of peacetime strains and others unprecedented in nature and scope. The greater the change, the more difficult is the social adjustment.

The war caused millions of men and women to take on new functions, often in new physical locations and under new social conditions. These changes in function naturally impinged upon the children, whose world was largely that of their mothers and fathers. Particularly to the infants and children of preschool age the war was a reality in terms of the changes in the circumstances of their parents.

The problems of the wartime family were likewise in large part those of the child. Changes in the structure, functions, and relationships within the family had their repercussions in the personalities of the younger members, from infancy to adolescence. The disorganization and interruption of the family, either through separation, desertion, or death, had injurious effects upon the emotional security of the child whose father deserted his family, divorced them, or died in battle. Dr. Lois Meek Stoltz has covered this rather thoroughly in the paper she presented to the Midcentury White House Conference on Children and Youth.[1]

The most severe cases of emotional disorder among children in World War II were found in the belligerent countries, with Great Britain providing much of the available information on this score. A child guidance clinic in London reported that the largest group of symptoms exhibited by the children who had been subjected to such war strains as bombing or the loss of one or both of their parents were psychosomatic in character—that is, physiological symptoms with an emotional basis. These evidences of emotional inse-

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This article is based on a paper prepared while the author was a student at Wayne University. She draws upon her own observations made during travels in Europe. At present Mrs. McMackin is engaged in private duty nursing in Detroit.

curity included "bed-wetting, soiling, hysterical vomiting, sleep-walking, fits, and tics such as habitual grimacing, blinking, and shrugging, and so on." In other large groups such reactions as "anxiety states, depressions, hysteria, and the like" were observed. Other behavior took the form of "truancy, stealing, destructiveness, noisy and aggressive behavior, and running away," while still other children developed such personality traits as "seclusiveness, irritability, over-submissiveness, and defiance. . . ."[2]

AMERICAN psychiatrists and social workers point out that similar symptoms could be unearthed in the files of any child guidance clinic in the United States. Many children and adults in this country apparently reacted to the possibility of bombing and attack as they would have to the real thing. In such cases the fear was a very real emotion even though the basis for it rested in fantasy rather than fact. The emotional insecurity of the already emotionally unstable was heightened by changes in their routine, interruptions in their accustomed pattern of life, or the deprivation of one or both parents. This feeling of insecurity had many symptoms in the American child, even though the psychosomatic responses were not so serious as those observed among the children of London who had been forced to undergo real and tangible terrors.

If a child's social relationships were satisfactory many of the emotional repercussions of the war appear to have passed him by. If, on the other hand, he had other personality disorders they tended to be enhanced by the environmental changes of the war. A study made by Florence Young in Georgia from September 1942 to July 1945, in which she interviewed mothers of one hundred twenty children aged thirty-six to eighty-four months, concerning the effects of war on their children revealed that the most frequent cause of disturbance, noted in 25.9 percent of the subjects, was "wartime shortages and inconveniences" which precipitated irritability and fatigue in the mothers, thus affecting the children. Others in order were: father in service or soon to be inducted, 20.8 percent; war talk, 17.5 percent; war movies, 14.2 percent; housing, 10.8 percent; and war play, 10.8 percent.[3]

A study of children between the ages of

Courtesy of the U. S. Children's Bureau
—Photo by Esther Bubley

seven and thirteen undertaken at Bellevue Hospital indicated "the rather striking tendency of the children with severe personality disorders to weave their conflicts and anxieties into the war situation—which was used in such cases as a medium of expressing basic conflicts not necessarily created by the war."[4] The anxieties of the children in Bellevue were most clearly aroused by situations related to the family and their relationship to it. Behavior difficulties could therefore be expected "with a child who has had a home in which there has been a constant marked threat to his relationship with the parents. The frustrations and deprivations which such a child has been experiencing as a result of this unsatisfactory relationship will most probably become reinforced by any further threat to this relationship as a result of the war."[5] Neurotic children, whose latent fears were already aroused by the denial of affection or by insecurity in the parental relationship, were most vulnerable to the strains of a wartime society.

THE PROBLEMS of the child in wartime America were not associated with bombing and evacuation. Rather, they were somewhat similar to those of normal times, accentuated in areas of social mobility and social congestion, where the impact of the war upon the civilian front was particularly crucial. Some of the more pressing of these social problems were summarized with particular reference to their relationship to the child as follows: inadequate and insanitary housing as a serious hazard to the health of families in communities where war industries have brought a sudden influx of workers. Living conditions which make normal home life difficult, absence of fathers for military service, employment of mothers of young children, and night work and unusual strain of parents employed in war industries undermine family life and endanger the wellbeing of children.[6]

Other elements had such specific influences upon wartime children as the following: absence of parental guidance, freedom from restraints, and lack of protection of youth from dangerous influences in the community created problems of juvenile delinquency. Relaxation of school attendance and child labor laws, coupled with adolescent unrest, permits boys and girls to leave school before they are physically and mentally equipped for work. Unprecedented increases in child labor and youth employment due to wartime demands have increased manyfold the child labor problems of normal years.[7]

In the study of the effect of the war upon the children of London Dr. Robert D. Gillespie, psychiatrist of the Royal Air Force, found that the most devastating factor in the experience of bombed-out children was the interruption of their regular routine. Whether the child was evacuated from the city or not, if his regular schedule of eating, sleeping, going to school, and recreation was interrupted, his emotional stability might be seriously threatened.[8] This situation was naturally intensified for those children who lost one or more parents in the blitz. Anna Freud suggests that the most important consideration is not necessarily the change in social routine but rather the continued presence of the parents, with the love they alone can provide. "One year of work with England's refugee children," she states, "has revealed that a child can be bombed out, yet smile two minutes afterwards or sleep peacefully while a bomb makes a big crater in a garden less than fifty yards away. Love for the parents is so great that it is a far greater shock for a child to be suddenly separated from his mother than to have a house collapse on top of him."[9]

The emotional impact of wartime social changes on the child can only be inferred from his behavior. Many of the results upon the personality cannot be adequately determined at the time but must be taken into consideration in the behavior of later years.

In August 1948 I left Wayne University in Detroit where I was studying to accept a position as a pediatric supervisor with the department of the Army at the Port of Embarkation at Bremerhaven, Germany. This position afforded me the long anticipated opportunity to travel in Europe while on leave and to visit many of my friends in the various countries. There was Helene Walker, a Dutch schoolteacher who had known my brother and has since his death cared for his

grave at Margraten Cemetery close to her home in Kerkrade, and who had sent pictures and written so vividly of her country to me. Meeting her and her family was like renewing an old friendship. How I enjoyed their hospitality and listened almost unbelievingly as they related their experiences under the Nazi occupation.

In Holland (the Netherlands)

The influence which the war conditions in Holland have had upon the mental and bodily condition of numerous children has been of a varied nature. In addition to the thousands of Dutch children, who in recent years suffered or fell an indirect prey to Hitler's lust for blood and vengeance, there were two other groups of children. These two groups were collected in concentration camps in Holland and in the Dutch Indies.

About 20,000 of these children, principally Dutch Jewish children, were concentrated in two camps in Holland. Ninety percent of the children who survived a longer or shorter stay in these camps were sent to Poland in cattle trucks. On their arrival in Poland they were all gassed or knocked down and killed. No child returned from Poland. A doctor, with whom I talked in Amsterdam, said that these children lived in most unhygienic ghastly surroundings and received an insufficient quantity of food of very poor quality. Living in such crowded barracks they fell prey to many diseases. In addition they had to endure the cruelties of the Waffen-SS-men, who demanded strict discipline from children five years old and up. At different times children as young as ten were witnesses to mass killings of political prisoners. It was a long, long time before these children were able to regain their mental equilibrium and adjust themselves to normal human life.

In Camp Westerbork the family often remained intact, but here the lawlessness of the environment and the complete inability of the parents to exercise the necessary supervision led to licentiousness, crime, et cetera. You must remember that the conditions in these camps, especially the lack of sufficient food, in many cases totally changed the personality of one or both parents, which in itself provoked psychopathic reactions. Camp Westerbork contained people of all ages, from newborn babies to the oldest inhabitant of Amsterdam, a woman one hundred two years old.

AMONG THE small number of children who survived the concentration camps in Holland, in Belsen, or in Theresien Stadt, most had tuberculosis caused by contacts with open cases in the overcrowded barracks and by malnutrition. Furthermore they were maladjusted, which is easily understandable after a life of several years in concentration camps. I was amazed at the number of hospitals devoted to the care of children with tuberculosis as I traveled about Holland. Even some of the smallest towns, such as Kerkrade, had large hospitals devoted to this disease.

Most of these conditions held true for the second group of children who were returned to Holland in January 1946 from Japanese concentration camps in the Dutch East Indies. Neither children nor adults were gassed in these camps, but many died, principally from malnutrition and infections. General malnutrition caused cessation of growth, decrease of weight, general malaise, dizziness, edema, and other symptoms. These formerly lively European children who had lived in the tropics became indolent, lost their memories and were difficult to handle. It took a long time to correct these difficulties, and even in 1948, when I was there, the effects on the personality and social development of the children were very noticeable. My friend in Kerkrade, a teacher in the high school, and I spent many hours discussing the effects of the war on the children. She noted many problems not only in their ability to apply themselves to school work, but in their play relationships. They have grown up too quickly as a result of their harrowing experiences. In some groups one finds children with adult expressions and habits unable to participate in the life normal children led in the days prior to the occupation.

The deportation and extermination of so many Dutch Jews caused many problems. Because of their fear of being arrested they

hid, with their children or separately. In many cases the parents were found without the children and deported. When they were arrested in Amsterdam the children were separated from parents. The underground secretly snatched away many children, thus saving them from death. However, after the liberation, when it became evident that there were many homeless children whose parents had been killed or lost track of, peculiar problems arose because these children had often lived for several years in a surrounding socially and religiously quite different from that of their parents.

The condition of a large majority of the children who remained in the country during the years of occupation has been unfavorably influenced by many factors. In the large cities of Holland, especially in the western part, a breakdown in the family often occurred, caused by such factors as father in concentration camp or forced to work in Germany, and mother away from home for long hours standing in line for shopping. The children were starved physically and spiritually. More and more children took an active part in the black market, with its depressing effects.

As morality went down, large numbers of children showed neurotic, neuropathic, and psychopathic symptoms (enuresis, lack of concentration, vomiting, stuttering, stammering, and petty crime). After the liberation the food problems slowly improved. Other dangers arose, however, such as an increasing difficulty in finding adequate housing and an increase in congenital syphilis, practically unknown in Holland before the war.

Resistance in Holland was organized relatively late. It took the Dutch a long time to believe and to realize that "people could be so bad," as my friend said. They were bewildered and did not believe stories of the atrocities they heard about and had to suffer them before they realized the truth.

In France

The physical conditions of the children of France are similar to those already mentioned. However, there was a tremendous increase in juvenile delinquency, enuresis, and behavior problems. A definite breakdown in family unity existed during the war as a result of the draft of 1939, the many war prisoners in 1940, forced migration of people during the German occupation, deportation of the fathers to centers of war activities, and the immorality of the women in the absence of their husbands. Juvenile delinquency increased from 10,000 cases a year in 1939 to 40,000 cases each year during the war, and apparently this happened in all the other war-ridden countries, as well as the neutral countries such as Switzerland.

Many behavior problems increased in intensity upon the return of the father to his family. This was probably because of the fact that the normal solving of the Oedipus complex could not take place. Many boys became tyrants in their father's absence, and in many instances didn't even know their fathers and couldn't be reconciled to their return.

Behavior problems were especially acute in the Jewish children, owing to the destruction of family unity and their constant anxiety and fear of arrest, deportation, and so on—many families having to leave or move every week.

Children under three are not hurt mentally by war; but the damage starts especially with children aged three to five. The French children seemed to exhibit more deprivation as a result of war situations because of their historically overly affectionate natures.

In Sweden

Sture Seive, of Lund, Sweden, said, "Everything in a child's world revolves around the mother. The new generation is being formed by her, while the father is engaged in pursuing his special interest. Men may create work of more or less lasting value, yet only mothers are forming lives, shaping human beings." This has been true in Sweden, but the trend is toward including the father in the care of the infant and child. The child is highly regarded in presentday Swedish culture. To encourage a rise in the birth rate the government pays a stipend to the family at the birth of each child. In certain housing units the rent is adjusted according to the number of children in the family, and is lowered with each additional child until the seventh is

born. Then it is stabilized at the lowest figure. Every method is used to encourage more children—adequate housing, nursery schools, mental and medical clinics especially for children, et cetera.

Although Sweden was a neutral she did play an important part in the war as a refuge for many of the war orphans. Limited numbers were accepted and placed in Swedish homes where they were given a place of importance in keeping with the Swedish culture. There was some disruption of family life in the Swedish homes during the war, because while not actively fighting the Swedes were preparing to defend themselves. Even today the Swedish air force is ready for action. The young men spend two years in the air force and are then allowed to return to their homes. They have complete hospitals several stories underground in anticipation of an atomic attack, for they are across the sea from Russia. A great deal of their industry is involved in producing for defense. Therefore there have been problems in Sweden similar to ours in the United States during World War II. Some homes were without fathers; women were employed in industry; children were under a strain because of a very real threat of injury or death by bombing or other attacks. Today Sweden is experiencing unrest and insecurity because of the Russian situation, and this will in time affect the lives of the children. It is affecting the adolescents by interrupting their education for compulsory military training.

In Germany

There is a futility felt in approaching the German situation unless we have a basic knowledge of the dynamics of German behavior. I would like to refer you to Rudolph M. Wittenberg's paper, "Children Under the Nazi System" for a complete discussion on this subject.[10]

The Nazi state attempted to cut the child's normal emotional dependency ties to his parents and make the school, such as it was, and the social group the main source of satisfaction. The state also attempted to eliminate the family and the church. The Hitler Youth were taught to obey, not to think.

Children trained under Nazi ideology are abnormal. We must remember that many such children are growing up in Germany today. The effects of the war, per se, on the children from a physical standpoint are much the same as those found in previous discussions. It is the indoctrination of Nazi ideals that has had a profound influence on their lives.

The psychological elements observed in most Germans have been well summarized as follows: (1) Dependency of the citizen from birth to adulthood on authority. (2) Difficulty in moving from one social, political, economic, or religious circle into another. The pattern stems largely from the educational system which determines occupation. (3) Excessive rivalry between racial, religious, and political groups limits tolerance and prevents coordinated efforts for good of the general population.[11]

The displaced persons camps found in Germany for the most part contain children who were taken from countries occupied by Germany and placed in work or concentration camps. The outstanding characteristic of the children seen in these camps is their apathetic attitudes. What strikes one especially is the lack of spontaneity, and of emotional outbursts. *The Stars and Stripes*, an overseas Army publication, printed a photograph that illustrates this point. A number of American Army officers in Berlin invited the children from the DP camps in the vicinity and the children of the Army officers to a circus. The groups were separated for the photograph, which revealed a striking difference in the two. On the American side there was much clapping of hands, evidence of shouting, bodies rising up in their seats—in general, a photograph depicting excitement, laughter, and surprise. On the other hand, on the DP side there were just a lot of glum faces, faces staring, bodies just sitting—a picture registering chiefly bewilderment and quiet behavior.

It seemed to me in visiting these various camps and groups in Germany that I witnessed various degrees of emotional impoverishment. They were children who were as emotionally starved as their bodies were physically depleted.

In the DP camp for children at Rosenheim, near Munich, they had a party during a religious festival in which gifts were distributed to the children. The children all marched up in single file, received their gifts, and walked down. When a remark was made about how well behaved they were the UNRRA director pointed out that that was the trouble with them: they went through the whole experience without the proper emotion of children—no noise, no shouting, no tearing into the packages; they displayed just emotional dulling. It was a pathetic picture to witness.

In Switzerland

Switzerland was not involved in World War II, yet life was deeply altered from the first day of the war. Every man in Switzerland—married or not married, and without consideration of the number of children—had to do military service. Men were absent from two to two and a half years during the war. A new tax provided the means to support the families of soldiers at the level of their prewar income. The burden of bringing up and educating the children fell on the mothers alone. Together with other difficulties of wartime—such as nutrition, clothing, and heating problems—this induced nervousness and behavior difficulties in many cases.

More important were the effects of war on the refugee children. Jewish children came from Germany in 1933 and in increasing numbers thereafter. More came via the Vichy territory when France was occupied. The Red Cross sent many children to Switzerland. These children were placed with Swiss families after medical examinations at the frontier. Many were observed in Children's Hospital at Basel, the border town between Germany and Switzerland. They were of French, Belgian, Dutch, English, Polish, and Italian origin, and during 1947 they came from Germany also.

Their state of nutrition was poor but improved rapidly with adequate diet. Language differences caused considerable difficulty. Every attempt was made to place youngsters in a group speaking the same language, but this was not always possible. To offset this, kindergarten teachers were sent to teach the children music, drawing, painting, modeling with clay, and other handicrafts through which means they could express themselves. In their drawings they expressed the many horrible war experiences they had suffered. There is an interesting difference in the drawings of American children and others, such as the British. The American child is apt to show identification with the bombing plane rather than with the bombed city, whereas the British child identifies himself with the victims of these bombs.

The tendency to cruelty and aggression which many of them expressed in their behavior must be understood as a consequence of the war. Seeing so much cruelty and brutality, so little goodness and charity, the children are prone to take cruelty as the essence of the world, as the only means to continue living. It may necessitate a long struggle to give these children a better aspect of life.

Conclusion

Childhood memories for the majority of us are happy, but this is not so for the European child. His life has been dominated by fear; self preservation was all that counted. In many cases he was unable to speak his own language; was cold, hungry, living in filthy quarters; shown no kindness, only brutality. Many cannot read or write today.

Thirty-six countries are regarded as war devastated. In Europe there are four or five million children homeless and uprooted. There are thirty million individual homes destroyed. Fifteen nationalities are represented in DP camps in Germany.

In 1945 there were five hundred cases of severe mutilation of children in France alone. The children born after 1936 cannot even remember "normal times." Youth needs spiritual as well as physical rehabilitation. There is an attempt to reunite families and make child placements, but there are many difficulties inherent in this effort. How long will it take? What educational and psychological insight will be needed to erase the imprint of war and massacre from the wounded souls of the children victimized by the war and give them confidence in life and their

fellow human beings? They must be offered experiences of a completely different kind to counterbalance the shocks they have received. Only so can we restore mental health, hope, and faith. If we do not do so their inner conflicts may in many cases turn children into quarrelsome, embittered, and over sensitive young people who endanger the peace and security of human society.

The readjustment of the child in the postwar era must be considered in terms of the causative factors of war, with the realization that unless preventive measures are taken with the new generation a recurrence of the catastrophic dilemma we are now facing is inevitable.

You cannot omit the basic factors of economics, territorial expansion, ambitious leaders, and racial and religious prejudices which are the primary causes of war. But an equally determining factor, the psychological causes of war, must also be considered. War, then, assumes the role of a pseudotherapeutic agent for those individuals who are emotionally blocked and who are motivated by the drive for release of aggression. The parent, against whom the child's hostilities are directed, becomes a party to the responsibility for these psychological causes of war. The problem is not so much concerned with the readjustment of the child in the postwar era as with the readjustment of parental attitudes and intrinsic family relationships.

It is in this sphere that we as public health nurses can help families in molding positive attitudes which in turn will benefit the child. In an overall picture including both family and community facilities a reconstruction program might be set up as follows:

First, we must consider a reorganization of our educational system in terms of curriculum, democratic philosophy, and reduction of tensions in the regimentation of the child.

Second, child guidance clinics should be equipped to provide every child with the benefit of psychological care at the time problems arise in order to prevent further serious complications.

Third, every community should have recreational facilities adequate for all age groups, so that leisure time can be constructively spent.

Fourth, families should be encouraged to partake of recreational activities in unison to provide a common bond in their mutual interests.

Finally, the child should be made to feel so secure in his own family milieu that he is enabled to face the problems of a hostile world with confidence and self assurance.

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Marriage Counseling and the Nursing Profession

ABRAHAM STONE, M.D.

CHANGING SOCIAL, economic, and cultural conditions in our country are bringing about many changes in marriage and family living. The rapid transitions from an agricultural to an industrial society, from a predominantly rural and rooted to an urban and mobile population, the change from a large to a small family system, the increasing participation of women in industry, trade, and the professions—these and many other factors are gradually altering the character of American family life.

The changes are both in the form and functions of the family. From an authoritarian and patriarchal type the American family is today becoming more democratic and companionate in form. The roles of husband and wife and children are shifting, with a trend toward greater equality and personal freedom. Less emphasis is placed today on the family's economic, educational, and recreational functions and more on the emotional satisfactions and security, on the intimate interpersonal association which the home provides.

These transitions are, for the present at least, creating many added marital stresses and strains. There are more conjugal conflicts, more marital maladjustments, greater family instability. Not that conflicts in marriage are new. Husbands and wives, parents and children have disagreed and quarreled, broken up and made up from the beginning of time. Even Adam and Eve had their differences in the Garden of Eden. Formerly, however, in spite of conflicts, marriage and the family were held together by the external forces of law and religion, of social mores and social pressures. Today these outer forces are no longer able to sustain an unstable marriage. For its survival the family needs strong inner resources, an inner unity, an inner harmony and cohesion. To create this inner strength there is an ever growing social need for better education and preparation for marriage as well as for marriage guidance and counseling as an aid toward family stability.

The family is the basic unit of our society. As the human organism is made up of individual cells, so is our social organism composed of individual families. And as the well-being of the body depends upon the soundness and health of its component cells, so does social health depend upon the stability of the family units.

From time to time some of the cells in the body fall ill. They become weakened and disorganized. This is the basis of physical pathology. If the sickness is severe the cells or the organ may cease to function altogether; they may even die and may have to be surgically removed. In the vast majority of instances, however, medical treatment and nursing care may succeed in restoring the cells to normal health and the organs to normal activity.

Families, too, sometimes fall ill. Their balance is disturbed and they cease to function as a unit. This constitutes marital pathology. The illness may be due to personality disturbances of either one of the couple; to difficulties in interpersonal relations, the result of cultural, temperamental, sexual, or other incompatibilities; or it may be due to environmental or social factors which impinge upon the marriage from the outside. If the illness is severe enough it

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may require a surgical procedure, the severance and dissolution of the family. Sometimes this is the only feasible measure. But not all marital illness requires surgery. Understanding care and supportive treatment, the provision of needed information or the reformation of neurotic attitudes, the removal of irritating influences, competent guidance and counseling—these are often able to restore a disturbed family to good functioning—and living.

THE DOCTOR'S interest in family life stems from two main sources. First, there has been in recent years an increasing medical awareness of the profound impact of the social environment and emotional factors upon health and disease. The tensions and anxieties which a person encounters in his daily life, especially in his home and family circle, are likely to have a marked effect upon both his physical and his psychological wellbeing. It has been found, for example, that people with functional disturbances of the stomach have a high incidence of marital difficulties. When there is no sweetness in the home, it seems, the stomach is apt to turn sour; and when a man finds his marriage situation "hard to swallow" he is likely to develop stomach ulcers. Similarly, a woman may develop a dermatological condition or an itch because her husband "gets under her skin"; and arterial hypertension is often due to too much domestic tension and contention. In consulting with a patient a doctor is therefore apt to inquire: "How do you get along at home?" And this opens the gate wide for a discussion of marital and family situations.

In addition to this specifically medical approach some physicians have of late been taking an increasing interest in marital and family relations as a specialized branch of medical and social practice. Many of the marital conflicts are normally brought to the physician because they revolve around the physical aspects of sex and reproduction and are therefore considered by the couple themselves to lie within the realm of medicine. It is but a short step for the doctor who takes a special interest in these physical aspects of marriage to become concerned also with the psychological and social phases of family and marital adjustments.

As a clinical practice marriage counseling dates back about a quarter of a century. The first official consultation service, as far as I can determine, was established in Berlin in 1925. It was initiated at that time as a part of the social welfare system of the then democratic German government. Later marriage counseling spread into Austria and into some of the Scandinavian countries. In the United States the first marriage consultation center was established in 1929 by Dr. Hannah Stone and myself at the Labor Temple in New York. This center was subsequently moved to the Community Church where it has continued to function actively until the present. In 1930 the American Institute of Family Relations was opened in Los Angeles by Paul Popenoe, and in 1932 the Marriage Council, under the direction of Dr. Emily H. Mudd, was established in Philadelphia. Since then counseling centers have been organized in many cities, generally under the auspices of one or more community organizations—social welfare agencies, planned parenthood leagues, church groups, or youth centers. In some cities marriage counseling services are now emerging as a cooperative community project.

As a result of the increasing need for marriage guidance and of the advancing knowledge in this area, marriage counseling is emerging today as an accepted social service. Indicative of its rapid development was the organization of the American Association of Marriage Counselors in 1942, the first national group to recognize marriage counseling as a distinct social discipline. Today more people are becoming professionally interested in this field, more literature is appearing on the subject, more research is being carried on, standards for counselors are being evolved, and special training programs are being developed in several centers.

WHO, THEN, SHALL be the marriage counselor? For the present, at least, marriage counseling is interprofessional in character, yet those who enter the field, from whatever profession, require a common body

of scientific knowledge, of technical skills, and personal qualifications. A degree in theology or law, in social work or psychology, in nursing or even in medicine or psychiatry, does not in itself provide an individual with the necessary qualifications for marriage counseling. In addition he must acquire specialized knowledge and experience, special preparation and training.

Several years ago the American Association of Marriage Counselors and the National Council of Family Relations adopted a set of standards for counselors, defining in a general way the desirable requirements in academic training, professional experience, and personal qualifications. "Every marriage counselor," the standards read, "shall have a graduate or professional degree from an approved institution as a minimum qualification." This degree can be in one of several fields, but the studies should include courses in elements of psychiatry, human biology, sociology of marriage and the family, family law, and counseling technics. In addition the individual "shall have had at least three years of recognized professional experience subsequent to obtaining his degree," experience, that is, in his own chosen profession, and also actual experience in marriage counseling under approved supervision. Furthermore, "the candidate shall possess personal and professional integrity in accordance with accepted ethical standards." These are the requirements, in brief. Fuller details may be obtained from the organizations mentioned.

Even the trained marriage counselor cannot, of course, deal with all types of marital maladjustments. Frequently he may have to refer a patient to a specialist in some particular field—to a psychiatrist or gynecologist, to a social service agency or an attorney or to a minister. Being interprofessional in character, marriage guidance often requires the cooperation of many disciplines. It is, in fact, one of the marks of competence of a counselor to recognize when referrals have to be made and the resources available for that purpose.

What about the nurse, then? Nursing is included in the list of the acceptable professions mentioned in the standards. During the course of her professional education the nurse acquires a considerable body of knowledge about the physical and emotional factors involved in human relations. To the bedside nurse patients talk freely about many of their personal and family problems. Whether on private duty, in the clinic, in the field, or in the physician's office, the nurse is recognized as one who possesses special knowledge and special skills in dealing with people and human problems. If she is warm, sympathetic, and understanding in her relations, she will exercise considerable psychotherapeutic influence upon those who come under her care. Yet her training as a nurse, valuable as it is, does not in itself qualify her for marriage counseling. If she expects to deal with marital and family problems in a professional capacity, she must acquire much additional information and training.

There may be some in the nursing profession, especially those who are trained in the field of psychiatric nursing, who may develop a special interest in marriage counseling and who, through further study and training, will acquire the necessary preparation and experience to deal with marital relations. Without this preparation, however, it is wiser for the nurse to refer marital problems to counseling centers established for such purposes. The nurse should acquaint herself with the available resources in her own community so that she may direct those who seek her aid to the qualified sources. Information about such sources of reference may be obtained from the American Association of Marriage Counselors, from the local social welfare agencies, from planned parenthood organizations or mental hygiene associations.

THERE IS AN AREA of marriage counseling, however, in which the nurse can well take a more active role—that is, in the field of preventive guidance, in education and preparation for marriage. Here the nurse, and especially the public health nurse, has a great opportunity, for she epitomizes the newer thought in medicine, that of prevention. Through her contacts in the community, in health centers, in social agencies, she can stimulate and direct adequate marriage education, disseminate accurate information, and

inculcate sound attitudes toward marriage and family life.

Marriage counseling has a twofold function: it is both curative and preventive. When dealing with an ailing marriage the counselor's function is to make a proper diagnosis, determine the etiological factors, and apply corrective therapy. Through information and clarification, counsel and guidance, psychotherapy or medical care, as the case may be, the counselor attempts to give the couple greater insight into the underlying causes of their discord, to bring about a better understanding and a better adjustment in the marriage, and, when possible, to correct the marital illness.

Not all ailing marriages can, of course, be remedied. For many an unhappy marriage the best solution is dissolution. Some individuals are so immature, neurotic, or even psychotic that they are unable to make a stable adjustment with any mate. There are marriages, again, where the differences in background, in culture, in standards, in attitudes, in sexual needs, between husband and wife are so marked that only a separation will permit each of them to function normally. Then there are marriages where external factors—in-laws, illness, unemployment, poverty —undermine the foundation of the relationship, and divorce becomes the only feasible remedy. But even then marriage counseling can have great value in aiding the couple to achieve a legal separation without the indignity, hostility, bitterness, and aggression which are a part of most of our divorce actions today.

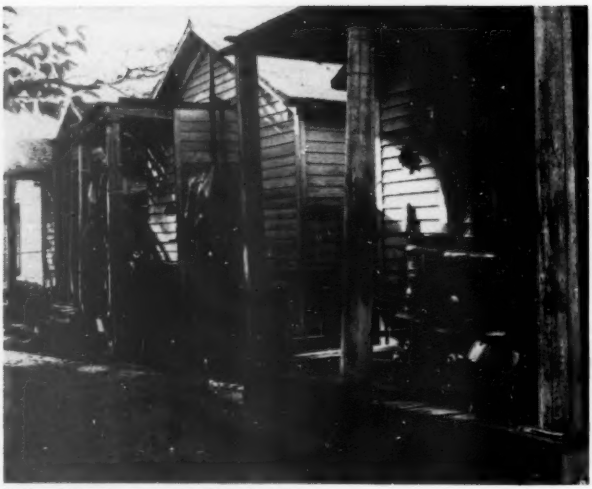
The chief task of marriage counseling in the future, however, will lie in the field of prevention. In all sciences relating to individual or social pathology this is the main emphasis today, and it is particularly applicable in the field of marriage counseling.

Medicine, for example, concerned itself for a long time mainly with the treatment of disease, the cure of disturbed bodily conditions. As the causes of disease began to be discovered, as man learned more about bacteria and vitamins and hormones, about physiological processes and the causes of their disturbance, the emphasis shifted from cure to prevention. Today we are endeavoring as far as possible to prevent the development of disease and to improve human health through a variety of medical measures and public health care.

In psychiatry, too, as the dynamics of human behavior began to be unveiled and the etiology of mental and emotional disturbances better understood, the emphasis shifted from psychotherapy to mental hygiene—to the prevention of emotional disturbances and the improvement of mental health.

The same holds true of marriage counseling. Now that we are beginning to understand some of the causes that generate marital discord the next step is to develop preventive measures. In this field the basis of prevention is adequate education for marriage and family life. By stressing the values of a happy family, by inculcating sound attitudes toward sex and marriage, and family planning, by providing needed biological and psychological information, many of the marital ills of today could be prevented and marital stability greatly furthered.

To meet the ever growing need for marriage and family preparation many national organizations have in recent years been developing active programs. The social welfare agencies, the American Social Hygiene Association, planned parenthood organizations, the National Council of Family Relations—these and other groups are today initiating plans for education and preparation for marriage in the home, the school, and the community. In this task the nurse can play an active and important role. Trained as she is in human physiology and psychology and in the dynamics of human relations, she can serve as a leaven and a leader in the program of marriage education.



National Housing Agency. Photo by Oliver

Housing And Health

NATHANIEL S. KEITH

PUBLIC HEALTH NURSES have long recognized the ill effects of slum housing on the families they care for. It is natural, therefore, that they are interested in the slum clearance and urban redevelopment program authorized by Title I of the Housing Act of 1949. Public health nurses play a major role in helping Americans to health and consequently, a better life. The slum clearance and urban redevelopment program has a like aim, the relief of human misery caused by slums and blight. The following portion of the Declaration of National Housing Policy from the Housing Act of 1949 emphasizes that goal:

"The Congress hereby declares that the general welfare and security of the nation and the health and living standards of its people require housing production and related community development sufficient to remedy the serious housing shortage, the elimination of substandard and other inadequate housing through the clearance of slums and blighted areas, and the realization as soon as feasible of the goal of a decent home and a suitable living environment for every American family, thus contributing to the development and redevelopment of communities and to the advancement of the growth, wealth, and security of the nation." That declaration is unequivocal in placing its primary emphasis on the welfare of American citizens. And it applies, of course, not only to the slum clearance and urban redevelopment program but also to all programs of the federal government which deal with housing. Among these are the Federal Housing Administration's activities in underwriting housing mortgages, the guarantee of veterans' home loans by the Veterans Administration, the low-rent public housing program administered by the Public Housing Administration, the Housing and Home Finance Agency's research program designed to lower building costs and improve construction technics, and other related programs.

No one can appreciate better than public health workers the danger of slums. It certainly is not true that all diseases originate in slums. But it is true that many more cases of

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tuberculosis and other morbid diseases are spawned in slums than in decent neighborhoods. For example, we have the situation in Cincinnati, where studies have shown that tuberculosis and pneumonia mortality rates in the Basin slum area have been significantly higher than those in the rest of the city. Of the white population, Basin dwellers in 1939-41 died from tuberculosis at nearly three times the rate for those living outside that area; and they died from pneumonia at almost two and one-half times that rate. Cincinnati's 1939-1941 death rate, it has been said, would have been about 15 percent lower had it not been for excessive mortality in the Basin area.

And Cincinnati doesn't stand alone in these dismal statistics. Milwaukee found that its worst areas sent more than twice as many patients to tuberculosis sanatoriums during the three-year period 1947-1949—in proportion to population—than the city as a whole. Detroit discovered that the pneumonia death rate in a slum area was three times the rate in a normal residential area, the infant mortality rate six times as high, and the tuberculosis rate ten and one-half times as high.

SURVEY AFTER SURVEY has brought out the same miserable facts—that slums have a persistent, evil effect on human health, that obliteration or even amelioration of many of our major diseases depends on improvement in living conditions. All across the nation our worst diseases are bred and fostered in slums —from Hartford, Connecticut, where one fourth of the population in bad housing produces more than one half of all local tuberculosis cases each year, to Los Angeles, where venereal disease rates in slums are thirteen times higher than those in better areas. On the other hand it has been shown conclusively that disease rates drop sharply when slum families are given clean, sanitary places in which to live.

There is no contesting the fact that slums breed disease. And they breed other vicious things. As the March 1951 issue of the *Crusader*, monthly magazine of the Wisconsin Anti-Tuberculosis Association, put it: "Slums breed tuberculosis. Slums breed delinquency and crime. Slums are tinderboxes for fires. Slums are ratholes for taxpayers' money. They bring in little tax revenue. They eat it up in fire protection, police protection, care of the tuberculous."

Let us look at some examples of the truth of those statements. One eastern city receives $108 more in per capita revenues from good residential areas than it spends there, but its slums cost $88 more per person than they yield. In one southern city the slum areas contribute only five and one-half percent of the city's real property taxes, but services in these areas require 53 percent of the city's health, police, fire, and other service expenditures. You may speculate for yourselves as to how much more money might be made available for health services if slums produced more taxes and consumed less.

There is just one answer to slums: get rid of them. Title I of the Housing Act of 1949, which set up the federal slum clearance and urban redevelopment program, exists because the Congress arrived at that same answer. Before the advent of the program most communities were unable to engage on a large scale in redeveloping areas which had been enveloped by slums and blight. This was true mainly because the majority of communities, limited financially, could not tackle the slum clearance job through their own resources alone. But now, for the first time in our history, with the help of federal loans and capital grants under Title I, communities can acquire, clear, and prepare for redevelopment the slums and blighted areas which heretofore had been out of their financial reach.

American communities are becoming increasingly aware of this opportunity for sound redevelopment of their worn-out areas. In the comparatively short life of the program —it has been in actual operation less than a year and a half—more than 430 localities have expressed their official interest. And more than 220 communities have begun actual participation in the program by obtaining reservations of capital grant funds. All eighteen American cities with populations of more than half a million are included. But it is worthy of emphasis that about one third of the communities involved have populations of less than 25,000, over one half have less

than 50,000, and about 70 percent are under the 100,000 mark. Certainly, then, this is not just a big-city program. The Housing and Home Finance Agency, of course, will do all it can to assist any participating community, regardless of its size.

Title I authorizes loans and capital grants for use by communities in eliminating slums and blighted areas through the assembly, clearance, preparation, and sale or lease of such land for development or redevelopment. The Housing and Home Finance Agency administers the program through the Division of Slum Clearance and Urban Redevelopment. Available for federal disbursement over a five-year period are one billion dollars in loans and one-half billion dollars in capital grants. These funds, of course, are to be used in the undertaking of specific local slum clearance projects.

Emphasizing the basic aim of the act to better the lot of these families living under the handicap of slums and blight, Title I allows federal financial assistance to be extended only for projects in which the areas involved either are predominantly residential in character before clearance or which will be devoted primarily to residential use after redevelopment. This provision permits loan and grant assistance to a large variety of projects in accordance with local plans.

BEYOND THE PROBLEM of clearance of slums there lies what the Housing and Home Finance Agency considers to be the program's core problem. That is the necessity for rehousing those families whose present dwellings will be destroyed by demolition in project areas. These families must be relocated in decent, safe, and sanitary homes at prices or rents within their means. Without such relocation no local program will attain the program's basic objective. Title I, therefore, provides specifically for adequate rehousing of displaced families, a condition that must be met by communities in order to secure federal financial aid.

The act also requires, in regard to relocation, that first preference be given displaced low-income families in admissions to federally-assisted low-rent housing projects. The latter are provided for in Title III of the Housing Act of 1949, which authorizes the construction of 810,000 units of low-rent public housing for the nation over a period of five years, beginning with the passage of the act in 1949. In communities participating in this program, responsibility for carrying out local operations rests with local housing authorities. In localities where both slum clearance and public housing are being undertaken there is a pressing need to establish a timing of operations which will find the public housing completed before families are dislocated from slum clearance project areas by the commencement of demolition. The public housing program nationally is under the jurisdiction of a constituent of the Housing and Home Finance Agency, the Public Housing Administration. There exists, of course, close operational liaison with that constituent agency.

Another need for sound relocation planning by the community is presented by the situation of displaced families whose incomes are too high to warrant admission to public housing projects. To meet this need communities must cooperate closely with private enterprise in probing all possibilities for the production of new housing either on cleared sites or in other acceptable neighborhoods and in the location of existing, adequate housing at prices or rents within reach of the families affected.

Directly aligned with family relocation is the problem of caring for the housing needs of minority groups located in project sites. Title I, in requiring rehousing of displaced families, specifies not only that there must be sufficient dwellings to accommodate the families but also that those dwellings be "available to" the families. That requirement was designed particularly to safeguard the interest of minority groups.

Liaison with the Public Housing Administration has been mentioned above. Another pertinent example of federal-level liaison designed to promote the betterment of health and living conditions for Americans is the Housing and Home Finance Agency agreement with the United States Public Health Service. Since 1938 the USPHS and the various housing agencies have worked cooperatively to meet specific needs. Soon after

the Housing Act of 1949 was passed an agreement for interagency collaboration on matters affecting the hygiene of housing was jointly announced by the Federal Security Agency and the Housing and Home Finance Agency. The agreement pledged the maximum use of the resources of the two agencies for the improvement of housing and community conditions. It called for a continuous exchange of information, cooperative planning of projects, allocations of working funds, assignment of technical personnel, and joint evaluation of cooperative projects.

Many of those interested in slum clearance and urban redevelopment have wondered, since the outbreak of the Korean war, what impact the defense effort would have on the program. Defense of the nation, naturally, comes first and always will come first. But no one can suggest that the present international situation reduces by one particle the need for throttling the evils of slums and blight. Beyond that, with democracy needing all the strength it can muster to counter the world-wide threat to its existence, this program presents an excellent example of democracy at its best. Therefore the policy of proceeding in all phases of the program as far as possible without interfering with defense requirements has been adopted. This policy provides for Housing and Home Finance Agency entrance into loan and grant contracts to finance land acquisition in localities under controls through which relocation, demolition, and actual redevelopment can be deferred if circumstances make it necessary in any particular locality.

There is no doubt that the success of this program will be a significant advance not only in the fight for better housing but also in the continuing war against the ills besetting too many Americans. That success will come only through the united effort of all those interested —local government, the federal government, private enterprise, and labor, and the active support of such groups as the National Organization for Public Health Nursing.

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Yale University School of Nursing

This paper was prepared by members of the faculty of the Yale University School of Nursing. It describes how the school provides learning experiences to help students gain an appreciation of the patient as an individual and as a member of a family and of society.

TO HELP STUDENTS gain an appreciation of the patient as an individual person and as a member of a family and of society is a major aim of nursing education. This goal of understanding the patient as a product of the interaction of the individual personality and social forces has been approached through the patient assignment method, through the preparation of nursing care studies, and through an increased use of patient-centered classes. The curriculum has been broadened to include such courses as The Family as a Social Unit and the Dynamics of Human Behavior, and continuous emphasis is placed on the preventive and public health aspects of illness. The fact that an increasing number of schools include psychiatric nursing in the basic program indicates an awareness of the contribution of psychiatric nursing experience to an understanding of human behavior.

Some of the measures used at Yale University School of Nursing to aid in meeting this aim of understanding the patient and the community are briefly presented.

Selection of Students

The delicate and intimate relationship of the nurse with her patients and coworkers calls for a depth of understanding and social wisdom. The more mature this understanding when the student enters the school the more effectively can it be expanded through her professional experiences. One of the requirements for admission to the Yale University School of Nursing is a baccalaureate degree from an approved college or university. We believe that the social experience and maturity of the student gained during the four years of college increase her ability to work with people. The intellectual capacity of the applicants is appraised through studying the results of the Graduate Record Examination and the college record. The physical health and emotional maturity of the applicants are evaluated as carefully as possible through physicians' reports, personal references, interviews, and autobiographical sketches. Although it is to be expected that the person who chooses nursing does so, at least in part, because of her interest in people, we frequently find in the autobiographical sketch of the college graduate a markedly mature appreciation of her social responsibilities.

The Curriculum

The curriculum is recognized as a series of experiences through which the student lives while in the school of nursing. The daily life situations in which the student finds herself enable her to assess her own attitudes about, and understanding of, human behavior. Every effort is made to make these daily experiences meaningful in these terms. In order to understand the role of the nurse and to begin to see herself fulfilling that role the student needs experience with people of all ages, sick and well, in real life situations—in their homes, in hospitals, in outpatient clinics, and in public health centers.

Beginning in the first term of the first year an attempt is made to broaden the student's

social experience. Early in the first term each student spends some time in the outpatient department, and during this period she accompanies a selected patient through the clinic routine. Thus very early in the student's experience she sees people worried, comforted, and relieved; she hears varied terminology with adequate or inadequate explanations; she sees one patient grasp explanations readily while another is temporarily confused; she sees the help of agencies enlisted for those patients who need their help.

There is a growing realization that mass methods cannot be used, and that each nurse-patient-doctor relationship is unique. This experience is under the guidance of the public health coordinator (a fulltime nurse member of the faculty) who discusses the experience with the student in terms of the observed patient's needs and reactions. Emphasis is placed on the socioeconomic-psychologic facets of the total picture.

Also in the first term there have been courses in Sociology, taught by a member of the University Department of Sociology; in Problems of the Individual in Relation to Illness, taught by a social worker; and in Health Teaching, taught by the public health nurse. This year these courses have been integrated with some of the introductory nursing discussions to form the first part of the Introduction to Nursing. The social worker, the public health nurse, and the nursing instructor joined forces in presenting this course. Also the three University chaplains—Protestant, Catholic and Jewish—contributed in a joint discussion on Religion in Illness. This integrated course seems to be a good first step toward understanding the patient.

During the second part of Introduction to Nursing the student is introduced to the actual care of patients through class discussions, laboratory work, and experience in the wards. In an attempt to focus the teaching on the patient rather than on the technics the course is planned around three hypothetical patients and the medical and social history of each. The emphasis is in terms of the total nursing care of each patient rather than the procedures concerned with the various systems of the body. Nursing skills are interpreted to include attitudes, empathy, and understanding, as well as manual dexterity.

THE CLINICAL assignments follow the traditional pattern—medicine, surgery, pediatrics, obstetrics, psychiatry, public health, and communicable disease nursing. Assignments to outpatient clinics are planned concurrently rather than as separate blocks of experience. In the hospital wards, in the outpatient department, and in the public health nursing and other community health agencies, psychiatrists, social workers, clinicians, and nurses are cooperating in the treatment of patients. The student thus has planned experiences in an environment where opportunities exist for total patient care. In all clinical teaching theory is correlated with practice and students are helped to apply the learned principles to their practice.

Methods of teaching which encourage student participation and independent study are employed. Students are encouraged to evaluate each clinical experience and to express their feelings about ways in which it might be more meaningful. They participate in the faculty study of curriculum revision.

The effect of patient-centered teaching is most dramatically illustrated in obstetrics, where, under the program of Rooming-In and Training for Childbirth as developed by the obstetric and pediatric staffs of the Medical School and the School of Nursing, the student sees total care with due regard for the patient's emotional needs. In this service the student experiences two aspects of interrelationships—the physician-nurse-mother team and the mother-father-baby family unit. The student is in attendance throughout the mother's labor and delivery, and her written assignment is on The Emotional Factors of Labor and Delivery. Thus she gains a concept of the importance of this particular life experience.

In teaching the nursing care of children emphasis is placed on emotional growth and personality development—in classes, in supervision, and in the assignment of patients. Observation in a nursery school is an integral part of the assignment to the pediatric service and is combined with actual practice of nursery school technics on the children's

wards. The hospital visiting hours on the children's wards have been interpreted flexibly and mothers are permitted and encouraged to spend more time with their children. Here again the student gains some understanding of the family unit and of the nurse's responsibility in helping the mothers.

In the psychiatric department the teaching of both physicians and nurses is dynamically oriented. Class discussion centers on personality development—normal emotional development, the common difficulties of each developmental stage, and the development of sick behavior. Emphasis is placed on the role of the nurse as an active, aware, and knowledgeable member of the therapeutic team.

On the medical and surgical services the rehabilitation of the patient is stressed in treatment and nursing care. This introduces a new concept in nursing education inasmuch as it takes more time and skill on the part of the nurse to help the patient help himself than to keep to the traditional pattern of "doing for" the patient. There is good opportunity for the student, under supervision, to gain in the art of human understanding.

Continuity in the care of the patient when he comes from the home to the hospital and goes from the hospital to his home, with emphasis upon the attendant need for interagency reporting, is presented to the student early in her course as an important part of medical nursing care. This appeals to the student because her patient becomes more quickly individualized if she knows something about him when she begins to give nursing care. When her care is no longer necessary she is very much interested in knowing what is going to happen to him.

Direct contact by telephone with another health agency helps the student to see herself as an important factor in the continued care of the patient. It also makes very real to her the many adjustments often necessary within the family group.

This new emphasis on rehabilitative efforts has demonstrated in a very practical way the need for close working relationships with many types of agencies to secure the best recovery possible for the individual patient. Again and again the student has seen this work out and so her appreciation of its need is based on actual experience.

A limited number of carefully selected observations, outside of the immediate school setting, are correlated with other experiences the student is having and are well supported by preparatory and evaluation conferences.

DURING THE two-month affiliation with the local visiting nurse association the student is introduced to health and sickness situations in the home with the family as the unit under care. Selection of families is governed by certain general principles, reflected in questions such as these: In what way will experience with this family further the growth of the student? Can she handle the situation adequately? Will it be a challenge which she is prepared to meet? Will it create a feeling of insecurity? What clinical experience is offered? In what way will the selection of this family for student experience affect service to the community?

During this experience the student gains markedly in her ability to teach, in her appreciation of the value of the past experience of the families with which she is working, and in her ability to be thoughtfully observant, to recognize needs as they arise, and to give help at that point.

Although our program at Yale stresses the importance of the whole person and does consider some of his emotional needs as well as those sociological forces which are most apparent in the patient's recovery, we do not believe that it is complete. The curriculum could be strengthened by further consideration of the role of anthropological forces—of those influences that determine many of the unique biases and difficulties of the particular patient.

Our study of the individual patient still, perhaps, tends too largely to be descriptive in its focus on the various areas of influence. More focus on the dynamics of the patient's feelings and behavior (and of our own) is needed in order to give more effective patient care. There are to be sure some services, like obstetrics and psychiatry, in which a great deal of attention is paid to what the patient knows and feels about her condition, what

makes her know and feel the way she does, and how the nurse can work most effectively with her. In obstetrics it has been dramatically proven that the feelings of the patient and her understanding of her condition have a great influence on the amount of pain she feels, and even sometimes on the successful completion of her pregnancy.

On the pediatric service an increasing use of movies concerning the behavior of children shows the student nurse the importance of working more closely with children in order, for instance, to prepare them emotionally for surgery, and even for acceptance of the hospital situation. More must be done in the skilled use of play to reduce the behavior problems of the children and even to keep some behavior problems from developing in the child who has to stay long periods of time in the hospital. This has called for the addition of a person trained in nursery school work who is skilled not only in the use of play equipment but in the understanding of the needs and behavior of individual children and who can help teach this to nurses. Our aim is to integrate the two areas of obstetrics and pediatrics in order to strengthen the concepts of human development and interpersonal relationships. Mention has been made of the social-rehabilitative facilities increasingly available for many patients (particularly on the orthopedic service) but we are well aware that the emotional needs of all patients, in rehabilitation work and elsewhere, are not yet sufficiently met.

Like others, the Yale University School of Nursing faculty has spent much time on the consideration of curriculum revision. Many questions have arisen the solution of which would help in furthering our aims in education. Do the surgical wards of the hospital, where scientific advances demand particularly skilled and complicated nursing care, lend themselves as well as they once did to the training of the nurse who is beginning her ward experience? Should the beginning student assist with the play of children on the pediatric wards in order to learn more about the dynamics of behavior? It has been said that the student enters the school of nursing nearer to the community than she is after two years of training. Should she have experience early in the curriculum in the outpatient department to expand her concepts firsthand in situations where the psychological, sociological, and cultural influences obviously play a large part in the medical-surgical condition of the patient and where the use of nursing dexterity is frequently not too exacting? Should psychiatry come earlier in the basic curriculum?

The increased training in manual skills of the practical nurse means that the education of the student nurse must be redefined to increase her ability to work more skillfully with the complicated and ramified needs of each individual patient. This means that the nurse has to develop an ability to see more clearly what each patient needs and define her objectives with every patient; and that the art of teaching must be better understood by the nurse.

This implies more attention to the psychological readiness of the patient to learn and to the complicated factors which influence this readiness to learn. It also means that the nurse must be more adaptable in her role with the patient in order to meet his varied needs better, and it indicates need for reinterpretation of how nursing time should be spent.

IT IS ESSENTIAL to have faculty members who understand and accept these aims and methods of nursing education and who have the ability to implement, with their specialized subject matter, the skills of interpersonal relations and the understanding of human behavior. To improve the faculty approach to the attitudes, feelings, and responses of the student, realizing that these factors determine how she utilizes opportunities to work for the recovery of the patient, a number of faculty members have formed a discussion group, with a psychiatrist as leader, to explore these skills, and to assist their own orientation to dynamic concepts of behavior so that they may teach and supervise more effectively. We are considering the potential value of periodic individual conferences with a nondirective approach to help the student work

(Continued on page 691)

It Can Be Fun

RUTH M. SCOTT, R.N.

YOUR ANNUAL MEETING . . . bugaboo or delight . . . it's up to you. Annual meetings can be fun. We know, because the memory of our last one still brings a smile and even a chuckle in retrospect.

It is no news to you that annual meetings have a way of becoming progressively painful. Each year we face the world shattering decision as to whether it shall be a speaker or a forum. Should the focus be on agency services or must the broad view be taken to interpret the agency's relation to all public health?

At that point everybody connected with planning the annual meeting takes the dim view of trying to do anything but suffer through another dull event. The president of the board is ready to preside with a beribboned nosegay on her bosom, the staff prepares to take bows self consciously, and the executive is resigned to hearing her virtues extolled.

That is about the picture we faced when according to schedule our Public Relations Committee met to plan our annual meeting. Everybody was present. As usual, objectives were discussed and possible technics of presentation were explored. But this year it was different! Our committee chairman had the light touch. The director of public relations of our community chest had been invited to come as an adviser. Her whimsy and originality, plus that of our chairman, sparked the spontaneity of the rest. Everybody had ideas and tossed them into the hat amid chuckles and gales of laughter. Finally, it all simmered down—we would do a skit. It would be a farce based on this very committee meeting. It might be amusing to our public to witness the birth pangs of an annual meeting. We would portray a few of the ideas we had toyed with, and if at all possible the entire staff would participate in the venture. We wanted to use Polly, the public health nurse, for one scene. Polly is a mannequin dressed in an NOPHN uniform, who speaks via transcription. She is the brainchild of the Public Relations Committee chairman, who secured her and arranged to have the transcriptions cut at one of our local radio stations. He wrote the script for Polly's first transcription. She has had a very successful career, having attended many meetings, and once was interviewed on a radio program.

It took a subsequent meeting or two to complete the details for the annual meeting. Topics which we knew had appeal were selected: content of the nurse's bag, the baby bath, and how the supervising nurse works, plus Polly's newest transcription. The mechanics of the thing took a bit of doing. Our power and light company gratuitously provided two spotlights and installed them the day of the meeting. Our small staff was divided into groups for the three scenes. The script was written from the conversation of the three groups of nurses concerned with portraying each scene. Everybody caught the mood—it was light, relaxed, and nontechnical. Each group took the responsibility for the property used in its scene.

One bit of property, the revolver with blank cartridges which was whipped from a board member's purse and fired unrehearsed early in the opening scene, was a distinct surprise to all and caused a near riot. But it had the effect of setting the stage for the nonsensical touches that followed and the switch ending.

We've had our first committee meeting for planning our annual meeting this year. And you guessed it—more fun coming up. We are commemorating the fiftieth year of our service, so we shall try our hand at a farcical pantomime replete with old uniforms and possibly vintage background music. *You* try the light touch at annual meetings. We recommend it, it's fun.

Miss Scott is director of the Public Health Nursing Service of Fort Wayne, Indiana.

Special Interest Groups in the ANA and NLA

This is the fourth of a series of articles on structure prepared by the Joint Coordinating Committee on Structure of the Six National Nursing Organizations.

THE PROPOSED PLAN for reorganizing the national nursing organizations holds every promise for concerted and coordinated action in nursing. In the American Nurses' Association (ANA) nurses in all occupational fields and in all types of positions will work together to improve the individual practice and welfare of nurses. In the Nursing League of America (NLA) nurses will work with allied professional groups, employers of nurses, and general citizens to develop and improve nursing education and organized nursing services in communities. Their work in both organizations should benefit all concerned—those who give the nursing service, those who receive and support nursing service, and those whose work is closely allied with nursing.*

It is obvious, then, that in both the ANA and NLA there will be many overall areas of common concern to all the members, no matter what their major or special interests may be. Moreover, these areas will be interrelated to a certain extent. What advances the general welfare of nurses advances the welfare of nurses who are interested in a specialty, such as tuberculosis or operating room nursing, and helps improve nursing service. What helps bring about better nursing education helps bring about better nursing service. What helps bring about more effective and coordinated nursing services in a community directly or indirectly benefits nonnurses and nurses, all of whom at some time are likely to be, or whose families are likely to be, consumers of nursing service.

These facts were recognized while planning for the reorganization of the six national nursing organizations. The national committees on structure were well aware of the need for coordinated action in nursing. But they were also aware that in addition to areas common to all nurses and all nursing there are many special areas where problems and interests may be different from those of other groups.

Past experience has shown that special interest groups are inclined to splinter off from an overall organization when they believe they have had too little opportunity to concentrate on their own unique problems. Once they work alone for a time and solve some of those problems they tend to realize their need to be part of the whole again.

The national committees on structure have accordingly recognized that if nursing is to be successfully reorganized and sufficiently coordinated in the two organizations of the future attention must focus not only on overall problems and interests but also on the problems and interests of special interest groups.

What Do All Nurses Most Need to Do?

All nurses have many problems and interests in common. No matter what their position, occupational field, or major interest may be, they need to get out in the local, state, and national communities and join in organizational activities with other nurses, allied professional groups, and general citi-

*See Your place in the new structure, PUBLIC HEALTH NURSING, September 1951; The ANA in the proposed structure, *American Journal of Nursing*, October 1951; The NLA in the proposed structure, PUBLIC HEALTH NURSING, November 1951.

zens. All nurses need to join in at least three important activities.

First, it is important that all nurses work toward improving their own practice and general welfare. This includes defining the standards, functions, and qualifications for practice in their own occupational field. It also includes promoting fair conditions of employment that will make it possible for them to give the best possible service and gain satisfaction from their work.

Second, it is outstandingly important that nurses work with allied professional groups and general citizens in developing and improving organized nursing service programs** in their own field. The kinds of workers needed to carry on the total program in an agency, the ways in which nursing services are organized within a community, their relationship to one another, the question of how funds may be raised and costs controlled, the administrative pattern of an organized nursing service, the question of how personnel employed by an agency can best be utilized, the share of lay boards and citizens committees in developing nursing services, the question whether a new design is needed for nursing services in communities—these are only a few aspects of organized nursing programs that may require special and continuing study.

Third, it is important that all nurses work toward improving nursing education programs in their own field. The basic, supplementary, continuing, or advanced education essential for various positions within that field may need special study and research. If proper facilities are not available attention should be called to that fact, recommendations made to proper authorities in educational institutions, and those institutions helped to develop or expand facilities. Sometimes this means that nursing education programs should be established on a sounder financial basis. This is work that definitely calls for coordinated action among nurses, allied professional workers, and general citizens. But it is work that might be left undone unless nurses take the initiative in promoting understanding of how and why it should be done.

What Do the Special Interest Groups Also Need to Do?

To speak through the American Nurses' Association and the Nursing League of America; to work toward improving their own practice and welfare; to help develop and improve organized nursing service programs in communities; and to work toward improving nursing education—these are what all nurses most need to do. However in many of these activities there are aspects that call for special consideration and some adjustment for special interest areas.

For instance, the standards and qualifications for practice within an occupational field may in certain respects be similar for all nurses in that occupational group. But in certain respects they may be different. As a nurse works in a special field she tends to become less adept in some general nursing skills and tends to develop special competency in those that are most essential in her special setting. In other words, the nursing skills, other abilities, and qualifications necessary to do good work in a special field are conditioned by that special setting. Therefore they usually require emphasis. Very often, too, employment conditions and occupational hazards peculiar to the special field may call for special consideration.

Also, in working to develop and improve organized nursing service programs in communities it may be important to concentrate on certain problems unique to certain types of community agencies. For example, the ratio of professional nurses to practical nurses or to auxiliary workers may be much more out of proportion in tuberculosis or psychiatric hospitals than in general hospitals. What to do about this disproportion, how to solve its related problems, may need more attention than that given to some other problem common to all types of hospitals.

In nursing education, too, there are special

** Organized nursing programs are those provided by community agencies. These include hospitals, convalescent homes, and other institutions; public health agencies that provide public health nursing service (including visiting nursing associations); schools and industrial plants that provide nursing service; and schools and programs for nursing education.

recommendations for objectives and content of field experience were formulated. A plan was made for assisting in the preparation of public health nurse faculty members in collegiate basic program.

Perhaps the most valuable outcome to conference participants was the increased understanding of one another as people, as well as representatives of university programs in public health nursing from coast to coast. Living, working, and playing together breed a kind of tolerance, mutual respect, and sharing which should increase the contribution of each of us to public health nursing education.

ELIZABETH HILBORN, R.N.
MARION I. MURPHY, R.N.

BOARD AND COMMITTEE MEMBERS SECTION

The Executive Committee of the Board and Committee Members Section met in New York City on October 24. It was a day of hard work spent in evaluating the section activities for the past year and making definite plans for the strategic months between now and the convention.

The committee heard reports from the chairman, Mrs. Philip A. Salmon; Mrs. C. Welles Belin, chairman, National General Membership Committee; Mrs. Marjory B. Hyde, membership secretary; Emilie G. Sargent, president of NOPHN; Mrs. Gilbert Pingree, vice-chairman of the section; and our general director, Anna Fillmore.

Mrs. Salmon has represented the committee at various NOPHN meetings and reported that she has been invited to be a member of the Advisory Committee on Citizen Participation of the Community Chests and Councils of America and the National Social Welfare Assembly. Mrs. Pingree represented the committee at the Council of Branches meeting held in Minneapolis in September.

Reports on NOPHN membership given by Mrs. Belin and Mrs. Hyde convinced the committeee that individual efforts to increase membership are fruitful and that the *Program Guides* sponsored by the section provide an effective medium for interpreting NOPHN. Progress is encouraging; there are 883 general members in the NOPHN today. The value of personal contacts in interesting new members was stressed by Mrs. Belin.

Trying to visualize the layman's place in the new structure strained the intellectual resources, imagination, and emotions of committee members. But Miss Sargent's description of the new NLA gave the group a sense of direction and reminded them that a purpose of the plan for two national nursing organizations is to allow nurses and nonnurses to work together for better nursing service and nursing education. It is vital that citizens working at the local, state, and national levels keep up the good work they are doing, enlarge their scope of activities, and increase their numbers.

Miss Fillmore in a brief report told about some of NOPHN's activities during the past year. Regional conferences, field work, special studies, planning for public health nursing in the national defense, publications, correspondence, and plans for reorganization were among the interesting subjects described. Her report again impressed upon the members of the committee how much public health nursing needs a national agency and the importance of participation in its program by all who believe in public health nursing.

Members of the committee checked the dates of June 16-20, 1952, to be in Atlantic City for the Biennial Convention. They made plans for helping general members have an interesting time, fun, and opportunity to get acquainted with board and committee members from other parts of the country. It was exciting news to learn that Mrs. Frances P. Bolton, member of the House of Representatives from Ohio, would be mistress of ceremonies at the NOPHN rally on Tuesday evening of convention week.

The following were present: Mrs. Philip A. Salmon, Schenectady, New York; Mrs. Gilbert Pingree, Grosse Pointe, Michigan; Mrs. Francis M. Archibald, Elizabeth, New Jersey; Mrs. Daniel N. Beers, Pittsfield, Massachusetts; Frances K. Crouch, Alexandria, Virginia; Mrs. Lindsley F. Kimball, Manhasset, New York; Mrs. Paige D. L'Hommedieu, New Brunswick, New Jersey; Mrs. Ralph Pappenheimer, Cincinnati, Ohio; Ruth E. Rives, Buffalo, New York; Mrs. James J.

Secor, Perrysburg, Ohio; Emilie G. Sargent, Mrs. C. Welles Belin, Anna Fillmore, Mrs. Marjory B. Hyde, and Dorothy Rusby, secretary of the section.

ADVANCED PROGRAMS IN PSYCHIATRIC AND MENTAL HEALTH NURSING

A report of the conference on advanced programs in psychiatric and mental health nursing held in Cincinnati May 14-18, 1951, is now available. The objectives of the conference, a joint project of the NOPHN and the NLNE, were to identify common and unique elements in the programs and to explore and recommend what should be included in a psychiatric nursing curriculum. Several implications for the future development of psychiatric nursing were suggested in discussion and in reports of work groups.

Copies of the report may be secured from the NLNE without charge as long as the limited supply lasts.

ABOUT PEOPLE YOU KNOW

Two nationally known nurses, *Alma C. Haupt* and *Pearl McIver*, were among the fifteen distinguished alumni of the University of Minnesota to receive Outstanding Achievement Awards. Miss Haupt, director of the Nursing Bureau, MLI, was cited as "an eminent contributor to the health of the nation at war and at work," and Miss McIver, chief of the Division of Public Health Nursing, USPHS, as "a celebrated nurse and pioneer in the federal health services" . . . Among others who received these university awards were *Dr. Fred Adair*, *Dr. Herman E. Hilleboe*, *Dr. James Perkins*, *Dr. Edith L. Potter*, and *Dr. William P. Shepard*.

Alaska has been exerting its allure and has drawn several nurses from the states. *Anna Heisler*, who retired from the USPHS in 1950, arrived in Juneau in August to become acting director of the Division of Nursing, Alaska Department of Health. Miss Heisler will remain in this position while *Dorothy Whitney* is away on leave at Johns Hopkins . . . There is also a new assistant director in the department, *Gertrude Kunz*, who recently was educational director, VNA of St. Louis . . . *Anne Poore*, who has been director of nursing services in county health departments in Nebraska and Missouri, is now at Hoonah as senior public health nurse . . . *Monte Kyle* is on duty at Sitka. She had been on the staff of the Sacramento Health Department in California . . . *Edna Backen*, formerly with the Seattle-King County Health Department, is now itinerant public health nurse with headquarters at Naknek.

The Cambridge VNA (Massachusetts) announces the appointment of *Esther Deming* as field supervisor. . . . *Evelyn G. Johnson* is the newly appointed educational director of the VNA of St. Louis. . . . The Board of the VNA of Boston announces the appointment of *Mary M. Sullivan* as general director. Miss Sullivan was recently assistant chief, Federal Employees Health Branch, Division of Hospitals, FSA. . . . *Jane Harshberger*, formerly instructor and chairman of the Maternity Department, Boston University School of Nursing, has accepted the position of adviser in public health nursing (maternal and child health) with the Maryland State Department of Health.

Two nurses who have contributed notably to nursing progress retired in October: *Colonel Mary G. Phillips*, chief of the Army Nurse Corps, and *Katharine E. Peirce*, assistant to the director, Visiting Nurse Service, John Hancock Mutual Life Insurance Company. Colonel Phillips served as an Army nurse for twenty-two years and saw the Army Nurse Corps through the critical years of its development. Miss Peirce was with the John Hancock nursing service for twenty-two years also. She was a member of many NOPHN committees during that period, but in recent years has been most closely connected with the work of the Cost Analyses Committee and the Working Committee for the Study of Costs in Public Health Nursing. Miss Peirce was loaned to the NOPHN to help in setting up the new NOPHN cost analysis method. Her consultation at headquarters has always been highly valued.

Margaret Reid resigned as educational director of the MLI Nursing Bureau to become public health nursing consultant in the Connecticut State Department of Health. Miss Reid originated the *Quarterly Bulletin*, a

publication for MLI nurses, which many other nurses have found helpful. . . . *Mrs. Edna S. Gould* is now coordinator in public health nursing to schools of nursing in Illinois. She is employed by the Bureau of Nursing of the State Department of Public Health, which also announces the appointment of *Mrs. Mildred Moore* as consultant to nurses in industry.

Kathleen M. Leahy, director, Public Health Nursing Program of Study, University of Washington School of Nursing, is on sabbatical leave from the university to work on a special project for WHO in Europe. . . . *Kathryn Worrell,* formerly hospital nursing consultant, Michigan Department of Health, has joined the Children's Bureau staff. . . . *Marion I. Murphy* has been appointed resident lecturer in public health nursing at the School of Public Health, University of Michigan. She resigned as associate professor of public health nursing at the university in order to take graduate study there.

The American Red Cross reports several changes in and appointments to the staff of the Nursing Services in the past few months. *Mrs. Mary Atkins* has been transferred from the Southeastern Area to the Atlanta Chapter where she assumes the position of director of Nursing Services. . . . Recently appointed nursing field representatives are *Elizabeth Hornell* (in western Pennsylvania) *Marion E. McGrath* (eastern Ohio) *Mildred L. Salmond* (western Massachusetts and Vermont) *Kathryn L. Shay* (West Virginia) *Anita Smith* (western New York) *Alice L. Spellman* (eastern New York) *Edith E. Wekselblatt* (Delaware and New Jersey) *Elizabeth G. Hill* (Maine and New Hampshire) *Doris M. Jacobs* (Louisiana) *Mary E. Williams* (eastern Tennessee) *Maybelle Sacher* (southern Michigan) *Bernyce Bieganski* (northern Wisconsin and the upper peninsula of Michigan) *Mrs. Sigrid H. Bullard* (central California).

Margaret K. Schafer received the annual literary award of *The Modern Hospital* for her paper "These Tests Help the Hospital to Measure Nursing Quality" published in July 1950. Miss Schafer is assistant chief, Hospital Nurse Section, Division of Medical and Hospital Resources, USPHS. . . . At the San Francisco meeting of the APHA *Sally Lucas Jean* received the Elisabeth S. Prentiss National Award in Health Education. The award is presented annually by the Cleveland Health Museum. Miss Jean was cited as "school nurse, teacher of teachers, godmother of health educators."

Loyola University reports the following news about public health nursing faculty: *Hylda Harp* has been appointed instructor and field coordinator in public health nursing, and *Mrs. Mildred M. J. Moore* is lecturer in industrial nursing. . . . *Apollonia F. Olson,* who has been on the USPHS staff, is now director of the Public Health Nursing Section of the Oregon State Board of Health. . . . *Mrs. Margaret Longshore* has been awarded the Pennsylvania SNA's second gold medal. Mrs. Longshore is a school nurse in McKean County and is active in many community health projects.

CARMELITA C. HEARST

On October 9 Carmelita Calderwood Hearst died in Cedar Falls, Iowa. Her death is a great loss to the nursing profession and to all those privileged to know her personally. Mrs. Hearst was on the headquarters staff as consultant in orthopedic nursing, Joint Orthopedic Nursing Advisory Service, in 1941.

During the last two years Mrs. Hearst completed revisions of the textbook *Orthopedic Nursing* by Funsten and Calderwood and the JONAS handbook *Orthopedic Nursing—Content and Method of the Teaching Program in Schools of Nursing.* These publications and her many articles have been a fine contribution to nursing education.

In 1950 the National Foundation for Infantile Paralysis presented an award to Mrs. Hearst for five years outstanding service with women's voluntary groups. At the time of her death she was a member of the Joint Council on Orthopedic Nursing and the Advisory Committee, JONAS.

See page 705 for NOPHN Field Schedule

NEWS AND VIEWS

PLEASE NOTE

Because of a typographical error in the newsnote last month about "Gravida and Para" (p. 644) the examples may have confused and puzzled you. The first example should have read, "Gravida 1, Para 0, means a first pregnancy, no births."

Will you please make this correction in your November issue?

PILOT STUDY IN COMBINATION SERVICES

The City Council of Pittsburgh passed a resolution in July authorizing the Bureau of Public Health Nursing to undertake in cooperation with the Visiting Nurse Association of Allegheny County a pilot study for the combination of public health nursing services in the Arsenal Health Center area, serving around 36,000 people. The resolution provides the machinery for various administrative factors, such as the exchange of staff between the two services and the collection of fees by the nurses of the Bureau of Public Health Nursing.

We can all look forward to interesting developments when the Pittsburgh study gets under way. Such experimentation will do much to further the extension of complete public health nursing services in communities.

IT PAYS TO DRIVE SAFELY

Here's an award of special interest to public health nursing agencies! The National Safety Council has announced the establishment of the Carol Lane Award to recognize and reward women's achievements in the traffic safety field. The award will be administered by the Nsc through a grant from the Shell Oil Company. Miss Lane, whose name the award bears, is women's travel director of the company and a noted lecturer, columnist, and travel authority.

First prize will be a $1,000 defense bond and a statuette created for the award by an outstanding sculptor. Distinctive plaques will also be awarded to three additional winners. Presentation of awards will start at the next National Safety Congress in October 1952. Entries will be accepted through June 30, 1952, based on activities conducted during the calendar year of 1951.

Women's organizations are urged to sponsor entrants for the award. "Because women are most effective in inspiring and teaching safety, their efforts must be stimulated by every available means."

Additional information and entry blanks may be obtained from Miss Alice Catherine Mills, director of women's activities, National Safety Council, 425 North Michigan Avenue, Chicago 11, Illinois.

NEW EDITION OF *INFANT CARE*

Publication of the ninth edition of this booklet has been announced by the Children's Bureau. *Infant Care* has been a best seller since it was first introduced in 1914. More than 28,000,000 copies translated into eight languages have been distributed. Fan mail has been tremendous over the years. It is "the book" to countless young parents. May be purchased from the Government Printing Office. Price 20 cents.

HEALTH EDUCATION OF THE PUBLIC

The International Union for Health Education of the Public was organized in Paris last summer. At present it is functioning as an interim commission, but it is expected that a constitution will be adopted and a permanent organization established at the next meeting in 1952. The International Union is a nonofficial group similar in nature to the World Medical Society and the International Council of Nurses. Dr. C. E. Turner, assistant to the president, Nfip, and emeritus professor of public health, Massachusetts

Institute of Technology, is chairman of the interim commission.

SAFETY STANDARDS

The first number of *Safety Standards*, a new federal magazine, has been issued. This publication is the successor to the *Safety Bulletin* and *Federal Safety News* and will expand the scope covered in them. The August issue features articles on special technics in the handling of disturbed patients in mental institutions, and the defense safety program of the U. S. Department of Labor. A limited number of free copies will be available each month from the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

PROFESSIONAL EXAMINATION SERVICE

The Merit System Service of the American Public Health Association will hereafter be known as the Professional Examination Service. The Executive Board of the APHA announced this change in recognition of the expanding program of services to groups other than those operating under merit system or civil service regulations. VNA directors will be interested in the *Staff Nurse Selective Test*. See PUBLIC HEALTH NURSING, November 1951, page 645. Inquiries about the examination services should be sent to Lillian D. Long, Ph.D., director, PES, 1790 Broadway, New York 19, New York.

COMMUNITY HEALTH PLANNING

The National Health Council has prepared a kit, "Aid to Community Health Planning," to assist communities start new health councils or improve existing ones. The material in the kit includes information about programs, activities, structure, and financing of health councils, as well as sample constitutions and bylaws. Specific programs of active councils are described.

The kit may be borrowed for a month at a time or purchased for $2.50 from the National Health Council, 1790 Broadway, New York 19, New York.

NOPHN FIELD SCHEDULE—NOVEMBER

Marjorie L. Adams	Huntington, N. Y. Nassau County, N. Y. Norwalk, Conn.
Helen V. Connors	Pittsburgh, Pa.
M. Olwen Davies	Washington, D. C. Baltimore, Md.
Ruth Fisher	New Orleans, La. Norristown, Pa. Allentown, Pa. Pittsburgh, Pa.
Helen Hartigan	Vicksburg, Miss.
Bessie Littman	Baltimore, Md. New York City
Dorothy Rusby	Nassau County, N. Y.
Jean South	Salt Lake City, Utah Ogden, Utah Louisville, Ky. Knoxville, Tenn.
Marie Swanson	Highland Park, Ill.
Judith E. Wallin	East St. Louis, Ill. Springfield, Ill. Decatur, Ill. Rock Island, Ill. Moline, Ill. East Moline, Ill. Peoria, Ill. Galesburg, Ill.

October field trips not previously reported: Marjorie L. Adams, Morristown, N. J., Biddeford and Southwest Harbor, Me.; Helen Hartigan, Tuskegee, Ala.

The High Protein, Low Calorie Diet... The Modern Dietary Answer to the Problem of Weight Reduction

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1. Newburgh, L. H.: Obesity: In Clinical Nutrition, edited by Jolliffe, N.; Tisdall, F. F., and Cannon, P. R., New York, Paul B. Hoeber, Inc., 1950, chap. 28, p. 689.
2. Kunde, M. M.: The Role of Hormones in the Treatment of Obesity, Ann. Int. Med. *28*:971 (May) 1948.
3. Strang, J. M.; McClugage, H. B., and Evans, F. A.: The Nitrogen Balance During Dietary Correction of Obesity, Am. J. M. Sc. *181*:336, 1931.

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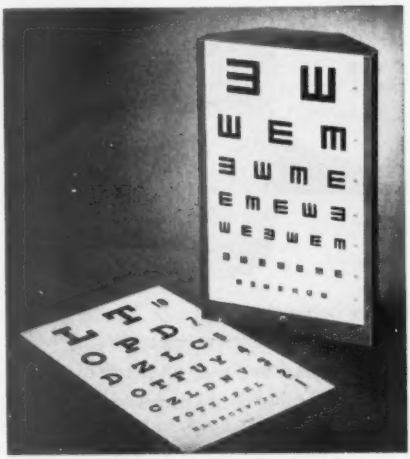

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WANTED—Staff nurse; generalized program; good personnel policies; good salary for qualified person; car necessary. Apply to Director, McLean County Health Department, 1009 North Park Street, Bloomington, Illinois.

WANTED—Public health nurse desiring experience in generalized program in southern Michigan, between Chicago and Detroit; salary from $3,000 to $3300 depending on qualifications and experience; depreciation and mileage allowance on own car; four weeks vacation yearly, liberal sick leave; field training area for public health nurses. Write to the Medical Director, District Health Department, Coldwater, Michigan.

WANTED—July 1, 1952: Director for public health nursing agency; 15 miles from Philadelphia; generalized service; 5-nurse staff; car provided; retirement plan; minimum salary $4,100; minimum requirements: PHN certificate and two years of experience as supervisor in public health agency. Write to Mrs. Lewis C. Dick, Jarden Road, Philadelphia 18, Pennsylvania.

WANTED—Staff nurses for generalized program in rural resort area of southwestern Michigan; salary commensurate with experience and qualifications; travel allowance $36 a month plus 4c a mile; liberal personnel policies; 4 weeks annual vacation; active public health training center. Write to A. B. Mitchell, M.D., Medical Director, Van Buren County Health Department, Paw Paw, Michigan.

WANTED—December 1: Two physical therapists; graduates of approved schools of physical therapy preferred; agency program offers service to cerebral palsied, post-poliomyelitis, and other crippled patients; 5-day week, liberal holidays, vacations, sick leave. Write to R. G. Forbes, Personnel Director, The Court House, Arlington, Virginia.

WANTED—Graduate registered nurses. Staff nursing in maternity and infant care, and gynecology; excellent experience in delivery room and rooming-in plan available; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; social security provided. Apply to Superintendent of Nurses, St. Louis Maternity Hospital, 630 South Kingshighway, St. Louis, Missouri.

WANTED—Senior staff nurse and staff nurse; generalized program in northwestern Ohio, rural area, 60,000 population; state retirement plan; vacation and sick leave; $60 a month travel allowance in own car; requirements for senior staff nurse: minimum two years public health education and supervised experience in generalized program; beginning salary $3,000; salary for staff nurse $230. Write to Wood County Department of Health, Bowling Green, Ohio.

NEWS RELEASE

The Coordinating Council for Cerebral Palsy in New York City, Inc., will again sponsor this year a two-week multiprofessional institute on cerebral palsy, to be given from January 21 through February 1, 1952. Tuition will be $25.

Following the Institute, and starting on February 4, 1952, the Council will offer, in cooperation with the College of Physicians and Surgeons, Columbia University, a three-month postgraduate cerebral palsy course for qualified physicians, occupational and physical therapists. A professional statement of completion will be granted by Columbia University upon satisfactory completion of the three-month course. Tuition for this course is $250, and may include, if desired, the Institute.

A limited number of scholarships are available.

Full information and application blanks may be obtained from Miss Marguerite Abbott, Executive Director, The Coordinating Council for Cerebral Palsy in New York City, Inc., 270 Park Avenue, New York 17, New York. *(Paid advt.)*

WANTED—The American Red Cross offers excellent employment opportunities as nursing field representative for nurses qualified in the field of public health education. Qualifications: bachelor's degree in public health nursing, nursing education, or health education, with at least two years of experience. Openings are available in the various sections of the country. Salaries are commensurate with training and experience. Inquiries should be directed to Mr. Norman A. Durfee, National Director, Personnel Services, American National Red Cross, Washington 13, D.C.

WANTED—Public health nurses and supervisor in tuberculosis, Baltimore County Health Department; population 270,000; suburban, industrialized, and rural areas; county seat 8 miles from Baltimore; generalized service including progressive school program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and special preparation in tuberculosis nursing required; beginning salary $4,000. Public health nurses: qualified, salary $3,000-$3,300; junior nurse, salary $2,600-$2,800; trainee, $2,500. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Qualified staff nurse, voluntary agency; excellent personnel policies, pleasant surroundings, excellent working conditions; interesting experience; good salaries. Apply to Director, Visiting Nurse Association, 194 Concord Street, Manchester, New Hampshire.

WANTED—Public health nurses for generalized program in suburban area; staff education and students; 5-day week, vacation, sick leave, and retirement benefits. Write to Mr. R. G. Forbes, Personnel Director, The Court House, Arlington, Virginia.

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WANTED—Graduate registered nurses. General duty in Medicine, Surgery, Operating Room, and Recovery Room; experience available in Neurosurgery, Chest, Plastic, G.U., et cetera; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; social security provided. Apply to Superintendent of Nurses, Barnes Hospital, 600 South Kingshighway Boulevard, St. Louis, Missouri.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,852-$3,536; graduate nurses as assistant PHNs, $2,540-$2,972; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

WANTED—Graduate registered nurses. General duty in Eye, Ear, Nose, and Throat services and Psychiatry; salary $225 a month for 44-hour week, increases in six months, one year, two years; $20 differential for evening and night duty; $30 a month additional for Psychiatric Nursing; social security provided. Apply to Superintendent of Nurses, McMillan Hospital, 640 South Kingshighway, St. Louis, Missouri.

WANTED—Graduate registered nurses. General duty in outpatient department; experience available in all services; salary $225 a month for 44-hour week, increases in six months, one year, two years; social security provided. Apply to Superintendent of Nurses, Washington University Clinics, 607 South Euclid, St. Louis, Missouri.

WANTED—Public health nurses, New York City Department of Health; immediate appointment on provisional basis; generalized service includes maternal and child care, school health and communicable disease control; starting salary $2,650; 37-hour week, liberal vacation and sick time allowance, pension rights, inservice training; applicants (except New York State veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, New York.

Begin your career or bring your experience to OREGON. Local health departments have openings now for alert, imaginative public health nurses. Generalized programs; established personnel policies; individualized placement; salaries from $260 to $380. Write to A. T. Johnson, Merit System Supervisor, Oregon State Board of Health, Portland, Oregon.

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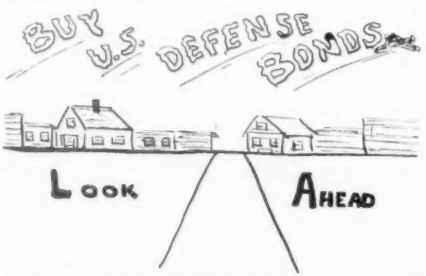

interest areas that call for special consideration. The continuing and advanced education essential for nurses who want to be specialists —particularly to teach a specialty—may need study over and beyond that given to education for all nurses. If there are problems unique to a specialty special research in that area may be one way of finding solutions. If additional facilities are needed to establish an educational program for a special aspect of nursing a way must be found to establish them.

Nurses in the special interest groups also need to see that two-way channels are developed between them and other workers in their special field. The nurses should keep posted on new developments in that field and on what allied professional workers are doing. In this way their special nursing skills will be intensified and kept in line with current knowledge. Allied professional workers, in turn, must keep posted on new developments in nursing and on what nurses are doing in that special field. Inservice education, workshops, institutes, or conferences, and association with allied professional workers in organizational activities provide some of the two-way channels.

How Special Interest Activities Would Fit into the Proposed Structure

All special interest activities can be carried forward in the proposed structure, some in the ANA, others in the NLA. To gain an idea of how this might be done let's consider how one special interest group would participate in the two organizations. Any special interest group might be used as an illustration. But at random let's take general duty nurses whose major interest is tuberculosis.

Because they would be just as concerned as other nurses with improving the practice and welfare of all nurses they would join or continue their membership in the ANA through their district and state associations. If they meet the qualifications for membership as established by the General Duty Nurses Section, they would doubtless join that section in their state and in the ANA. They would work with all nurses in furthering better employment conditions through the economic security program and in promoting legislation concerned with general health and welfare programs. They would also work with other general duty nurses in defining standards and qualifications and in promoting satisfactory standards for practice as general duty nurses no matter in what type of hospital.

If they wish, tuberculosis nurses might meet occasionally by themselves as a subunit of the General Duty Nurses Section. Or because an interest in tuberculosis nursing cuts across occupational groups nurses in several ANA sections whose major interest is tuberculosis might want to hold intersectional meetings. For instance, if private duty nurses, general duty nurses, and public health nurses who are concerned primarily with tuberculosis want to meet together to consider improving their individual practice in caring for tuberculosis patients that would be possible.

Because tuberculosis nurses would be just as concerned with organized nursing service programs in communities and with nursing education, they would join the NLA, too. There they would sit down with administrators, board members, other nurses, allied professional workers, and consumers to improve those aspects of organized nursing service programs that relate to tuberculosis. In addition they would work with nurses in the various fields, teachers, other educators, administrators, and consumers to improve education in tuberculosis nursing.

When a general duty nurse in a tuberculosis hospital joins the NLA she would be asked to designate in which department she is most interested. This would probably be the Department of Hospital Nursing Services. She would be considered a member of that department, eligible to take part in appropriate meetings and to vote on the slate for the department's overall committee. She would also be eligible to participate in appropriate meetings of any other NLA department, whether in the Division of Nursing Services or the Division of Nursing Education, and in an NLA interdivisional council on tuberculosis nursing.

Meetings in both the ANA and NLA on tuberculosis nursing may assume increasing importance in the future. The present medi-

cal trend to include tuberculosis with other chest diseases and to treat tuberculous patients in general hospitals will undoubtedly bring about a new trend in nursing. All nurses will have to know a great deal about tuberculosis nursing, which may come to be less and less of a specialty.

What has been said of tuberculosis nurses and tuberculosis nursing in relation to both the ANA and NLA applies in much the same way to other special interest groups such as operating room nurses, nurses employed in schools, psychiatric nurses, mental health nurses, orthopedic nurses, nurse midwives, office nurses. All will have the opportunity to work on their own unique problems and interests as well as on overall problems and interests.

In the ANA, for example, it would be possible for nurses in schools to meet as a conference group of the section in which they are most interested. In the NLA they would probably want to organize a council or other group that would deal with the improvement of organized nursing services in schools and with education for school nursing.

Operating room nurses might want to meet as a conference group of the ANA General Duty Nurses Section to consider matters that relate to their welfare and individual practice. In the NLA they might want to meet as members of a Council on Operating Room Nursing under the Department of Hospital Nursing Services.

Psychiatric nurses, mental health nurses, orthopedic nurses, office nurses, and nurse midwives would also be eligible to meet as conference groups of one or more sections in the ANA. In the NLA they would meet in a departmental or interdivisional council related to their special interest.*** (In the ANA office nurses would probably be a conference group in the Unaffiliated Members Section.)

Each NLA interdivisional council would focus on both the educational and service aspects of a special subject. In each one there would be concern for seeing that nurses have the kind of preparation, both formal and in-service, they require to do a good job in their special area. There would be equal concern for seeing that organized nursing service programs are of such scope and caliber that the people will receive good nursing care both in general and in relation to that special aspect of nursing.

In addition it will be possible for the NLA, within the limit of available funds, to conduct special studies, sponsor workshops, institutes, or conferences for special interest groups and provide advisory service to agencies, communities, and nursing education units in hospitals, colleges, and universities. This would correspond to the work now being done by the Joint Orthopedic Nursing Advisory Service, the Joint Tuberculosis Nursing Advisory Service, and the joint psychiatric and mental health projects of the National League of Nursing Education and the National Organization for Public Health Nursing.

Relationship To Nonnursing Associations

No doubt some nurses will wonder about their relationship to nonnursing associations concerned with their area of special interest, such as the National Tuberculosis Association. In some instances nurses have already asked about the advisability of forming a section in such an association.

In the opinion of the Joint Coordinating Committee on Structure of the six national nursing organizations it may be desirable for nurses to take an active part in such an association either as individuals or as a group. This would give nurses the opportunity to work with the leaders in other professions within that specialty.

It is hoped, however, that if a nurses section is formed in a nonnursing organization it will not duplicate the functions of either the ANA or NLA. Instead it would be desirable for such a nurses section to act as the liaison between the ANA and NLA and the nonnursing association. In this capacity the nurses would acquaint the association with ANA and NLA work and literature, and keep ANA and NLA posted on current developments in the field covered by the nonnursing association. The

(Continued on page 685)

*** See The NLA in the proposed structure, PUBLIC HEALTH NURSING, November 1951.

Interviewing in Industry

HARRY W. DANIELS, Ph.D.

ON A RECENT consulting job in a plant which had a fine cafeteria I was allotted a temporary office in the factory. The employees had to line up at lunch time near this office. One day a girl came in, mistaking me for some member of management in the company, and let loose, before I could disabuse her, with a flood of criticism of the cafeteria and its food. Because I was busy the best way to get rid of her seemed to me at the time to say, "Uh-huh," and leave it at that. So I did.

About a week later she came in again and, as you can imagine, I felt some apprehension about what she was going to say. But I was mistaken. She said, "I'm sure glad to see that all I had to do was tell you about some of the things that were wrong with the food in there. You certainly got them taken care of in a hurry!"

I hadn't done anything but let her talk! But this story—one of many—illustrates the point that if you let a person "get it off his chest" you may have helped him solve his problem. One of the functions of the interview is this catharsis, which is the release of tension by talking it out.

Some industrial experts undertook a study of the effect of various working conditions on production at the Hawthorne plant of the Western Electric Company. They found some peculiar things, which they were not prepared for. They found, for example, that when you increased the light in the room where their selected sample of girl workers were you got increased production. So they reduced the light, expecting to get reduced production. But it didn't work that way—they continued to get high production from those girls. They found that they could diminish the light until it was almost as bad as dim moonlight before they got a serious dip in the production curve. They found many other queer results like this, but when they started talking to the girls involved they found out why. Because these girls had been chosen to be a group on which experimental work was done, and because the girls had, by working together in a new situation, formed a tight social group, they were motivated to show the experimenters just what they could produce, in spite of things like light and heat and rest pauses. The point to this story is obvious: that work is a form of social behavior, and that you don't always know from past experience what motivates people until you *talk to them.*

Henry Ford in 1913 established an advisory service to help his employees. But his purpose was to check up on them to see if they were "living right." "Right" meant, of course, what he thought was right. He hoped to do good for his employees by advising them on educational, vocational, and personal matters. During the time shortly after the advisory service was installed the average number of employees at Ford was 14,366. But during the same period 50,488 people left his employ—an astounding turnover.

And this story illustrates the point that although we know that talking with someone helps him the motive of the counselor, as seen by the person being counseled, is an important

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Dr. Daniels is now associated with Richardson, Bellows, Henry and Company, a firm of industrial psychologists engaged in research in many phases of human relations. When he presented this paper at the 1950 Conference of the Ohio Industrial Nurses Association Dr. Daniels was on the faculty of Cleveland College, Western Reserve University.

part of the process. A motive to improve the counselee by advice, no matter how well-intentioned we may be, just doesn't work. What I am trying to say here is that treating people as human beings is important in production, or in dollars and cents. And it's good sense too to realize that although we all think we know the answer to a person's problem when he comes to us with it people usually don't take advice. Do you?

We can see from these stories also the importance of *meaning*, the meaning people attach to their experiences. These meanings are just not logical—they are psychological. That is, people do not perceive what they ought to perceive according to what we would logically expect, but they attach meanings which are understandable only in the light of psychological knowledge. You can see this every day in experiences similar to this one:

I was attempting to diaper the youngest member of my family recently, in a father's fumbling way, with my two-year-old son looking on, as he usually watches his mother performing the same task. As I was painfully pinning the last pin, he said, "Aren't you going to salt her?"

You see, he had assigned meaning to the experience of diapering his sister according to his past experience. Without knowledge of his past experience his statement would have been unintelligible.

The behavior of workers and management, like that of all people, cannot be understood without an understanding of the way they see things. This implies an understanding of their needs, goals, attitudes, and many other *personality dynamics*.

Now we can see how the need for personal integrity can be expressed in a handshake—or a strike. Now we can understand why people do not say "I feel bad," but "The world is going to the dogs."

I once saw a man going to a football game. He parked his car just in front of mine (it was a flashy convertible). He obviously had his best girl with him and was out to make this a momentous occasion He had bought her a gigantic flower; they had pennants to wave; and he was encumbered with her fur coat, two seat pillows, his overcoat, a long scarf, and a large flask. When he began to fumble in his pockets for the tickets at the gate, we all stopped to watch him handle his burdens. It was really something to see the look of horror come slowly over his face as he realized that he must have forgotten the tickets!

You all have a prediction of how this man would react to the frustrating situation he was in. The way you think he would act depends on your own personality—the way you would react to a similar situation. But before the psychologist can feel free to predict the behavior of this man in this situation, he would have to find out all he could about the man's feelings, needs, fears, attitudes, and so on. We would have to understand him.

This understanding is best gained by the process of *empathy*. This means the ability to put yourself in the other person's shoes: the ability to feel as he feels, believe as he does, fear what he fears, need what he needs. This vicarious living of the life of another person enables the clinical psychologist to get the information he needs to reorient the personality of his patient. You too can use this principle in getting an inkling of the desires, aspirations, fears, and attitudes of the people you deal with.

The tool with which empathy is accomplished is the interview. It is the most valuable tool we know of today for determining what things mean to other people; for finding out problems of the kind I have been talking about; and sometimes even answering them; that is, for diagnosis and for therapy. The psychologist, the vocational counselor, the psychiatrist, the social worker, the personal counselor, the employment man, all use this tool. The industrial nurse can learn the technic, and can use this tool to good advantage because she is in a position to do more talking of this sort to people than almost anyone in the organization. Of course if the company you work for has a professional psychologist or counselor on the staff to perform these functions it is probably so large that no nurse will have time for interviewing. But in the large majority of cases no such person is available; employees and management almost thrust their personal problems on the nurse. She should be prepared to handle them.

With regard to the particulars of the technic which makes for a good interview a recent study I made of interviewing technic can be enlightening. I used a portable recorder to record employment interviews on the spot in employment offices all over the city. The recordings were made somewhat like those made on the Candid Microphone radio program, except that both parties to all the interviews knew that they were being recorded. These interviews were then analyzed for the technics used to get information from the applicants—one of the primary purposes of any employment interview. The technics most frequently used, in order of frequency, were direct questions, monosyllabic responses like "uh-huh," small talk not concerned with the business at hand, and suggestions and advice. But the analysis shows that the best ways of getting the applicant to talk about himself were not useful in the same order. In order of their relation with the applicant's volunteering information, the most useful were responses of all kinds, suggestions, and small talk.

The important thing about these results for our purposes is that these technics are *indirect,* that is, not questions. This method was first noticed and studied by Carl Rogers, an eminent psychologist. The method of interviewing advocated by Rogers, and substantiated by other recent studies, is called the nondirective method of interviewing. The point of it is merely to let the interviewee do the talking. Although this seems quite simple you would be surprised at the number of people who cannot listen, but must always do the talking. It seems to be quite difficult to listen, but that is the key word in interviewing: *Listen.*

A young Marine lieutenant left a will on the bomb-torn slopes of Iwo Jima, in which he left his estate, about $6,000, to the National Association of Manufacturers, the Congress of Industrial Organizations, and the American Federation of Labor, among others. The purpose of this bequest was to promote improved employer-employee relations in industry. The NAM added $16,000 to the $1200 it received and established two fellowships to explore ways and means of achieving Lieutenant Benjamin R. Toland's wish. The first study to come out of this project was that of Dr. Paul Pigors, *Effective Communication in Industry.*

This study has important connotations for all of us who are concerned with modern industry. Pigors shows that communication is not just one way, but both up and down. Even when no overt effort is made on the part of management there is communication from the top levels to the bottom levels of industry. But the reverse is not always true—communication from the workers to management is most difficult to achieve.

The industrial nurse is in an enviable position for the improvement of communication between workers and management in any organization through her skill in interviewing. This function should be recognized both by the nurse herself and by the members of management who are her supervisors. It should be an explicit part of her job. This communication of which I speak is not talebearing. No increase in morale was ever the result of violation of confidences. It is not accomplished either by accepting the surface behavior or the words people speak as the real problem. Communication of the sort which is effective involves the ability on the part of those concerned to assign the true psychological meaning to what people say and do—and to what they *don't* say and do. The warning I voiced above about the violation of confidences received in the interview is really unnecessary here because I am speaking to a group of nurses who understand both the ethical questions concerned and the therapeutic questions involved.

When you understand people you can control and predict their behavior. To understand people you must know them intimately, since what you must understand are the underlying systems of perception and the motives which determine their behavior. We know our close friends and our relatives in this way, and we often can predict how Aunt Suzie or brother Bill will react to this or that situation. The interview is our tool for getting to know people intimately in the shortest possible time. Of course it is not necessary for you to get to know the individuals with whom you come in contact well

enough to change their personalities—that is therapy. The interview as you should use it should be aimed at understanding why, in order to be able to increase the transfer of meaning from one individual to another, from one level to another. For this communication the interview is used only as a diagnostic tool.

For you to be able to interview well you must have a background of facts and theory about personality. The ability to diagnose implies a knowledge of the mechanisms by which we protect ourselves from injury: projection, rationalization, sublimation, regression, aggression, withdrawal, autism, repression, and others. Because of lack of time we cannot discuss all of these so-called *ego-defenses,* except to say that they are all means by which we solve our problems, and the differences in personality among people are partly due to their unconscious selection of one or more of these mechanisms when confronted with problems.

For down-to-earth practical instruction in interviewing it is possible to list some rules for being a good interviewer. The basic rule is this: *Be a person in whom people confide!* We all fancy ourselves this. But there are people who seem to have personalities which not only invite confidences, but somehow make others feel that just to talk to these individuals is a healing experience. These people, of course, will not have to be told how to interview. But for most people the following few rules are helpful:

1. Be good at your job. Nobody is going to come to you for help if you are in danger of being fired. Also, if you are secure, you will not view other people as threatening and can therefore be more at ease with them.

2. Be respectful of other people as human beings, with their own problems and their own ideas, and, most important, their own viewpoints. This is frequently more difficult than it sounds.

3. Become accepted by the people around you—be as "normal" as you can.

4. Talk the language used around you. This doesn't mean necessarily that you have to swear like a trooper, but a cuss word now and then can let people know you are not passing judgment on them for their use of cuss words.

5. Introduce new procedures slowly. This is a primary rule in any human relations situation. Remember that change is a very slow process, especially when you are dealing with human beings.

6. Keep your insights about people to yourself. As you get into the personalities of people you will find yourself knowing more about them than they know about themselves. Leave the interpretation of their personalities to the psychoanalysts.

7. Protect confidences. It is hardly necessary to tell nurses about this, but remember that you are *not* a stool pigeon for management or for labor. Keep the antagonisms and tensions of the continuous labor-management struggle out of your mind.

8. Make no moral judgments or inferences. This is absolutely essential and unfortunately the most difficult of all. But the quick, unconscious judgments that we habitually make on the actions and ideas of others are to be suspended during an interview. You should be able to listen to anything without batting an eyelash.

9. Give no advice. This, of course, follows from what we have said before, but it is desirable to make it explicit. You may think you have the solution to a problem, and you may really have it, but don't let the interviewee know about it. The whole idea of the interview is that the individual should solve his *own* problems.

We can assume all these precepts under one statement: *Be permissive.* And as for the technic of conducting the interview itself, the keynote is *listen.*

Such abundant knowledge about the people around you, the motives that activate them, and the way to handle them, makes the possessor of this knowledge of inestimable value to the organization as a whole. It enhances your value to your employer. If you can become a skillful interviewer you have in your power one of the most valuable tools at the disposal of human beings in their struggle to get along with other human beings. You will be, in other words, a consummate applied social psychologist. And don't forget to *listen.*

The Score Against Tuberculosis

JOHN H. SKAVLEM, M.D.

IN THE UNITED STATES one person in five on an average becomes infected with the tubercle bacillus. This ratio varies according to sections and areas of the country. Of these persons infected one in fifty develops the disease tuberculosis. Among those diseased one in ten dies.

Prevention is the best care of any disease. For tuberculosis we have methods, thoroughly organized and applied by doctors, nurses, and other health workers, which are very effective. BCG vaccination has been added as a specific measure. It is safe; it is effective to some extent. The immunity conferred on the person vaccinated is not complete or certain; it is not permanent. The procedure is still one to be used within recognized limitations, in selected groups of persons known to have unusually hazardous exposure to the infection, and very carefully controlled in application. It is not yet to be used for the general population.

Treatment of tuberculosis remains anchored to the basic pattern of rest, good nutrition, and a happy mind. This is best afforded in a hospital. The person with tuberculosis must heal himself. It is the body itself that builds up defenses to combat the invading germs and which heals the damaged tissues. We do not inherit tuberculosis. But we do inherit the ability, in great or less degree, to resist the infection once it becomes established in the body. The resistance naturally given to a person can be maintained and strengthened by healthful living or dissipated and lost by fatigue, poor nutrition, and intercurrent infections. Our efforts of treatment are directed to help the body destroy the germs and repair the injured parts.

To the fundamental pattern of rest in treatment have recently been added two wonderful scientific developments—new biological agents and chemical drugs and perfected chest surgery. The most effective biological agent is streptomycin. It has had the most thorough chemical, bacteriological, biological, animal experimental, and clinical testing of any agent yet used in medicine.

The action of streptomycin is to inhibit the growth and multiplication of the tubercle bacilli in the body. The natural forces of resistance in the average patient could withstand and overwhelm a single invasion of one generation of tubercle bacilli. But the rapid multiplication of invading germs from a few hundred to millions or billions in a few days is what kills the patient. Streptomycin cannot kill tubercle bacilli, but it is terrifically effective by its inhibiting action.

Certain drugs are given with streptomycin to increase its therapeutic potency and to reduce the development of drug resistance by the germ. The most effective drug for such purpose now used is para-aminosalicylic acid (PAS). Research in many centers continues in efforts to find agents even more effective than those described. There is definite promise that such discoveries will be made.

Pneumothorax, the oldest form of collapse therapy, is now being used with greater selectivity of cases to be so treated. Pneumoperitoneum is having increasing usage, together with phrenic nerve crush. Surgical col-

Dr. Skavlem is president of the American Trudeau Society. He prepared this paper for the forty-fifth annual Christmas seal sale of the National Tuberculosis Association.

lapse of the lung by thoracoplasty continues to offer very effective results for cavity closure in chosen cases. Resection, or removal of diseased lung in measure of segments, lobe, or whole lung, has resulted in rehabilitation and life for an increasing number of patients. Perfection of surgical technics, improvement in anesthesia, and the use of biological agents and chemical drugs have made such surgical procedures possible and safe.

Our goal is eradication. Our immediate practical aims are prevention, early diagnosis, and complete cure before destruction of tissue by the disease necessitates the application of procedures that involve permanent loss of function and parts to the body. The score against tuberculosis is turning more and more in favor of the patient and the population in general.

The score has been influenced in large measure by the work of the National Tuberculosis Association and its 3,000 affiliated associations throughout the country. Prevention is emphasized by the associations whose activities are primarily in the fields of education, casefinding, rehabilitation, and support of medical research. All work of the associations is financed from Christmas seal sale proceeds. Every Christmas seal purchaser, therefore, is contributing to the tuberculosis control program in this country, is helping to conquer a disease which ranks first among diseases as a cause of death in the age group from fifteen to thirty-five.

The TB Worker's Creed

I BELIEVE that what I have done—and others before me—has reduced the suffering and the deaths of my brothers from tuberculosis. I am grateful that the biological forces of nature and the improving environmental factors created by man have favored my work.

"I believe that the success of our past efforts has been furthered by the enlightened interest of my neighbor, my countryfolk, which has led to cooperation and support which exceeds self interest.

"I believe that my services have not yet reached every outstretched seeking hand. There is yet more for me to do.

"I pledge myself to my brother man to search out the many unknown cases of tuberculosis.

"I pledge that I shall treat each person equally in his misfortune, excusing myself not at all for my ignorance of his condition—of which he knows not himself.

"I shall help him and his to hold family and station.

"I shall help to restore him to pleasures of health, family, and work.

"This I shall do within my ability until tuberculosis no longer is found. I shall seek knowledge of things I do now or can do tomorrow.

"I shall hold to these tenets and oaths as long as they save suffering for the sick and protect others.

"These things I shall do, and shall help others who hold likewise."

ROBERT J. ANDERSON, M.D., *Chief, Division of Chronic Disease and Tuberculosis,* USPHS

Diet Suggestions for the Tuberculous on Low Income

The family approach is the key to a sound tuberculosis control program.

HERBERT R. EDWARDS, M.D., and JOYCE TURNER

THE PLACE and importance of diet in the treatment of tuberculosis have been an accepted dictum for many years. It is surprising to find, however, such a paucity of factual data to support the contention. There are few studies reported in the literature offering data which have not been complicated by other existing factors that also have a profound effect on the behavior of tuberculosis. Thus general economic conditions, overcrowding in slum areas, variable exposure to infection, all play a part. When, for instance, periods of improved economic conditions prevail in poor environments, the general wellbeing of the individual is improved. A classical example of this is to be found in a report by Downes[1] of a study of 194 families in the Harlem area of New York City during the five-year period, 1942-1947. It was an excellent epidemiological study with well balanced study and control groups. The economic improvement in the community during those years had a decided influence on the study and control groups of families and their reaction to tuberculosis. Although it was generally conceded that this study did not give final proof of the value of the nutrients used in the study group, the trend nevertheless did indicate a slight margin in favor of the extra nutrition that was given. Perhaps one of the most significant observations was the fact that the public health nurse could to an appreciable degree guide the food habits of families through her periodic visits and teaching of sound nutrition.

There have been other observations of large population groups that give further validity to the fact that an adequate, well balanced diet is important in the building of resistance to tuberculosis as well as other infections. Prior to World War I the tuberculosis death rates in Germany were among the lowest in the great nations. Following that war in a period of severe inflation, with a concomitant scarcity in basic food supplies, the death rate rose sharply. This was followed by a substantial reduction in the number of deaths when the economic situation was again stabilized.

A somewhat similar situation was noted at the outbreak of World War II. Those populations forced to live on reduced or starvation diets showed a prompt increase in their tuberculosis death rates. There of course were other factors, such as dislocation of the tuberculous population, overcrowding, and generally lower standards of living that reduced the resistance of those involved to disease of all sorts. In Great Britain this was controlled to a remarkable degree by the steps taken to regulate environmental factors as well as the provision of an adequate amount of food for the entire population. It will be recalled that white flour was replaced by a flour which was extracted from a higher percentage of the wheat kernel and thereby contained more

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protein, B vitamins, and minerals. This assured the entire population of greater nourishment from at least one source.

Observations of groups such as inmates of mental and penal institutions who were not subject to the social upheaval caused by war bear out the conclusion about the relation of undernourishment to tuberculosis. In fact, Marche and Gouvelle[2] go so far as to say "that nutritional deficiency is the prime factor" in tuberculosis. This conclusion is based upon careful analyses of the situations in France and Denmark and their personal research, and in their conclusion they state in part "a deficiency in animal protein appears to be an essential determining factor."

There are also experiences in the United States that bear out the general conclusion that the tuberculosis death rate declines when the economic factors in an environment permit an improved or higher dietary standard. It is a commonly known fact that tuberculosis is alway more prevalent in poverty-stricken or slum areas, and in such areas the dietary of the population is always well below the accepted minimum of human needs.

Thus, even though we may lack the specific scientific proof of the direct relation of food to the prevention and control of tuberculosis, our general observations are such that there can be little doubt that an adequate amount of the basic essentials in foods is important and that we should use every resource at our command to provide those elements for the tuberculous individual to hasten his cure and —of equal importance—to build the resistance of the contact to prevent the development of manifest disease from the infection that may be lurking in his system.

We must also remember that so far we do not have a specific cure for the disease. Even if such a miracle is discovered we will be confronted with that enormous army of individuals already diseased and their infected contacts. Furthermore, until a specific cure can be applied with equal force throughout the world wherever tuberculosis now exists there will remain the danger of spread of infection and disease. Continually improved transportation brings all peoples in closer contact than has ever been true before.

As a rule the hospitalized patient receives meals prepared under the supervision of trained dietitians. This is not true of ambulatory patients who have been discharged or who are waiting hospitalization. Obtaining an adequate diet is therefore a greater problem for these patients. The public health nurse and the nutritionist can possibly play a more important part than other persons in helping these patients improve their dietary practices. This fact has been demonstrated in Downes'[1] study in the Harlem area.

It is interesting that early medical writings reveal that physicians in ancient Greece recommended mother's milk or animal's milk which was still warm with animal heat.[3] The feeding of milk and eggs has been advised through the centuries and we reached a point in this country when clinicians were so impressed with the necessity for administering nourishment that stuffing the patient with eggs and milk and more eggs and milk became a common practice. This vogue of overfeeding resulted in overweight patients. It also placed an excessive burden on the excretory organs to eliminate the excess of foods that could not be assimilated by the body. Particularly this increased the respiratory rate, when the objective was to provide rest for the patient. Obesity, however, is not a sign of good health. McLester points out that gain in weight follows improvement, but improvement does not necessarily follow forced gain in weight. "Scrutiny of patients who have recovered from tuberculosis and who have long remained well is proof of the truth of this; they are seldom fat."[4]

The present concept of the tuberculosis diet therefore is not a "special diet" but rather an "optimum diet." Such a diet provides the same foods that would be recommended under normal circumstances, in slightly increased amounts. For the sake of comparison the daily normal and optimum diets are listed on the next page.

The optimum diet for an adult is arrived at by adding one pint of milk, one egg, and one serving of citrus fruit a day to the normal diet. This difference is based upon present knowledge which indicates an increased need for protein, vitamin A, and ascorbic acid

(vitamin C). Since these nutrients, especially protein, are so important in building the body's 'resistance to infection, it is highly desirable that both the active and arrested patient receive an optimum diet.

The length of time a patient should receive an optimum diet cannot be clearly defined but should be related to the fact that arrested lesions do reactivate and therefore it is important that every step be taken to maintain as high a level of resistance as possible until the lesion is considered inactive and the patient well established in a job. This may be two or more years, but in any event it is a much cheaper investment than to allow the disease to relapse, with all the sorrow that follows.

The same may be said of the contacts in a family exposed to the infection. Regardless of the presence of infection or some form of manifest disease these individuals present a potential hazard and therefore it is desirable to maintain them on an optimum diet, at least through the adolescent and young adult age periods where we see the beginning rise in morbidity and mortality, especially in the female group.

It is obvious, therefore, that the physician, public health nurse, and nutritionist must be prepared to give patients and their families simple and oft repeated advice relative to the expenditure of their funds so that an optimum diet can be assured as a permanent practice for years. We are not treating the tubercle bacillus per se or the changes shown by x-ray within the chest, but rather a person who is a member of a family which chooses and prepares food according to its own tradition, religion, and income; a person who has a host of ideas, some correct and others incorrect, about food, his family, himself, and tuberculosis.

It is not the scope of this paper to discuss the psychological or sociological aspects of feeding the ambulatory patient, but it should be borne in mind that these factors are always operating. It should also be remembered that the objective in making dietary recommendations is not to change the food habits but to modify them. Within the framework of the optimum diet as given in this paper it is possible in most instances to choose and prepare the particular foods which the patient prefers.

To assure the daily inclusion of the recommended foods it may be helpful to suggest that the patient follow a plan for regular meals. The meal patterns listed below serve as an example only, and may be adjusted to suit the individual patient.

Recommended Diets

Food	Normal	Optimum
	(No. of servings per day) *	
Milk	1 pint**	1 quart
Eggs	4-5 a week	2 a day
Meat or fish	1	1
Fruit	1 citrus	2 citrus
	1 other	1 other
Vegetables	3	3
Grains		
Cereal	1	1
Bread	3	3
Butter or margarine (tablespoons)	3	3

* The actual size of the serving depends upon the age, sex, and activity of the person

** 1 quart of milk recommended up to 20 years of age

Meal Patterns

Breakfast	Lunch	Dinner
Citrus fruit	Creamed soup	Meat, fish, or poultry
Cereal with milk	Sandwich or main dish	Potato
Egg	Raw vegetable	Green or yellow vegetable
Bread and margarine	Bread and margarine	Salad
Beverage	Milk	Bread and margarine
	Fruit	Fruit or milk dessert
		Milk

Regardless of the meal pattern which a patient and his family may choose there always seems to be the problem of purchasing it. Of the many aspects concerned with food selection the public health nurse is most involved in helping patients plan meals with limited funds. It is understandable that there would be numerous cases with this problem since there is a greater incidence of tuberculosis in low income groups.[5] Even if

the family had experienced a decent standard of living prior to the discovery of tuberculosis, the loss of income during the period of treatment and recovery might be sufficient to create this problem. It is wise then to secure information about the financial status of the patient before giving advice on diet. If the income is insufficient the patient should be referred to the appropriate agency for assistance.

Literature, motion pictures, and the various visual aids have their places, but the most important factor will be the personal relationship of the physician and nurse with the individual and his family. Habits can be modified when we devote enough time to clarifying the reasons for such change in the minds of the persons we are treating. These objectives can be obtained more readily if the services of a consulting nutritionist are available.

Once the income of the patient and other factors related to the family budget are known to the nurse she can begin to assist in planning meals at low cost. There are some general economy tips which might be suggested. They are listed according to the various food groups so that they may be referred to easily:

General Economy Tips

Food	Money Saving Suggestions
Milk	Buttermilk Evaporated milk Dried skim milk
Eggs	Brown or white, whichever are cheaper (they have same nutritional value)
Meat, fish, poultry	Less choice grades of meat such as "Good" "Commercial" Economical cuts, such as beef hamburg and chuck, breast of lamb or veal Organ meats such as liver, kidney, heart Fish in season Fricassee or stewing chicken
Fruits and vegetables	Fresh fruits and vegetables in season Canned fruits and vegetables (the various grades usually have same nutritious content) The less expensive dried fruits Potatoes (not only a cheaper vegetable but also of higher nutritional value than rice, macaroni, hominy grits, et cetera)
Cereal, and bread	Home cooked cereals (Whole grain cereals and breads—such as oatmeal, dark farina, whole wheat bread—provide more food value)
Butter or margarine	Margarine

Other economies related to proper storage and preparation and suggestions for serving the meal in an attractive manner should be discussed, but these details are available in leaflets and books on general nutrition.

It will be noted that the suggestions made for stretching the food dollar are those recommended for any situation where the income must be expended wisely. There is no special way to budget a tuberculosis patient's dollar, but particular attention must be given to economical selections so that none of the food groups need be eliminated from the diet. There is also another important reason for putting this information on a general basis. Although it is true that there are many unattached patients most patients are members of a family. To the nurse this means two things: (1) the patient will probably eat as do the other members of the family and (2) the members of the household are contacts of the patient and are in need of nutrition counseling which will guide them in selecting an optimum diet. The logical and most effective approach to this situation is to work with the family as a unit.

Actually the family approach is the key to a sound tuberculosis control program. It is only by teaching and assisting the family that we can hope to prevent the spread of tuberculosis. Many social welfare agencies now recognize this and make special financial arrangements for tuberculous families. But the granting of money is not enough. Burritt points out that "adequate amounts of food of suitable variety, not harmed too much in preparation, cooking, and serving, or by lack of refrigeration, can be secured often only by persistent teaching representing the combined judgment and skills of the physician, the public health nurse, and the nutritionist where one is available."[5]

To go one step further, it must be pointed

out that not only should nutrition teaching be persistent, it must be geared to the specific family. The Downes' study of situations in which public health nurses taught nutrition to the patients' families bears out the belief that routine teaching regarding a good diet for the patient had little or no effect upon the family dietary pattern.[6] Families usually regard recommendations for the patient's diet as therapeutic rather than preventive. The nurse must therefore clarify the purpose of the recommended diet as well as offer suggestions which will make it possible for the patient and his family to accept and purchase the diet.

The study referred to above also demonstrated that much can be accomplished through a program of special nutrition teaching by the public health nurse. The authors concluded that "families with a serious health problem, such as tuberculosis, probably are most receptive to teaching about the importance of nutrition for the maintenance of good health."[7] If we accept this concept along with the fact that ambulatory patients and their families need assistance in selecting adequate diets, we shall be encouraged to work even more diligently in this area.

It should be the policy of public relief agencies to augment the allowance of welfare families where tuberculosis is a problem to conform with the optimum diet previously suggested for the tuberculous individual and the family contacts. The amount of general assistance given to these families is usually at or close to a minimum for basic requirements and it seems wise in the case of children to maintain this diet up through at least twenty years of age. The general situation in these families is such that there is need for special emphasis on diet to maintain as far as possible the highest level of resistance in the individual. Again, it is money well spent and in the long run less costly to the tax dollar than relapse or incomplete cures.

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Special Interest Groups

(Continued from page 674)

nurses section would also guide the association in relation to nursing aspects of the specialty and help plan how resources might be pooled in the interest of stronger services for the people.

A Definite Place For All Special Interest Groups

There will be a definite place in both the ANA and NLA for all special interest groups in nursing. But it will be important to maintain a balance of interests. Although there is something unique to each special interest area there is a common thread that runs through all fields, all education for nursing, and all types of organized nursing service programs in communities. A special interest group will have to be considered in two relationships—as an entity with its own special problems and needs and as a part of the whole. It will be the objective of both organizations in the proposed structure of nursing to provide special interest groups with the opportunity to function in both relationships.

International Congresses of Note

Second International Poliomyelitis Congress

THREE YEARS AGO, after attending the First International Poliomyelitis Congress, I wrote a brief summary for PUBLIC HEALTH NURSING of impressions of the congress, which was held in New York City July 12-17, 1948. Now it is a privilege to put down my impressions of the second congress, held in Copenhagen, September 2-7, 1951. There was a certain basic similarity in the organization of the two congresses: excellent papers on epidemiology, virology, biological research, orthopedic, and medical aspects of the disease; fine discussions; scientific exhibits by the polio groups of many countries; and commercial exhibits, including respirators made in European countries. Then, of particular interest to the readers of this magazine were the demonstrations of nursing care and physical therapy. More about that in a moment.

One of the amazing differences for me between the two congresses was that here I was a foreigner, dependent upon my interpretation of hand language and of English spoken earnestly and well but frequently with a Danish or Turkish or Greek interpretation of our phonetics or special meanings. Occasionally it would take a cooperative team of one or two Americans and an equal number of friendly and patient Danes to get a satisfactory answer to a seemingly simple question. But fortunately a great percentage of the people attending the congress or helping us in the city had a good working knowledge of English.

From the moment our ship came into the pier we could feel the interest and friendliness of our hosts. Huge signs with personal welcomes greeted many of the passengers.

As in the first congress, the proceedings were broadcast in the lecture room in four languages. The papers were mimeographed in several languages and distributed daily. Actually the value of these congresses to nurses, physical therapists, and occupational therapists is not found in the formal involved technical papers but in the "coffee cup" discussions on the many philosophies of poliomyelitis care and rehabilitation. We came away from such meetings aware that all countries are trying to give good patient care, and that although each might be doing it a little differently, basically each is striving to improve. We all have much to give and much to learn.

Teresa Fallon, JONAS staff member, and I were the nurse members of the team which presented demonstrations on nursing care. Two doctors discussed the medical aspects of poliomyelitis, and we followed with demonstrations of the nursing care for the acutely ill patient, including bulbar care, respirator care, and bed positions. A team of two physical therapists from either the Georgia Warm Springs Foundation or Stanford University then demonstrated muscle testing and muscle reeducation and discussed rehabilitation and activities of daily living.

These demonstrations were presented twice daily over television. At that time Denmark did not have complete television facilities. There were no television sets in the homes. Receivers were set up in the two exhibit halls and in the coffee lounges of the halls and large numbers of doctors, nurses, and physical therapists congregated there to watch the performances.

We worked in a specially set up room. At first we found it difficult to speak slowly and to remember that our actions must be visible in either one or both of the cameras so that our unseen audience would get a good picture. Occasionally we would check the screen which was visible to us and find the picture quite disconcerting. One of us might be doing an important procedure and look up to find the screen showing the other partner stacking up the pillows for the next step of the demonstration. But all in all it was great fun, although I seriously doubt if any of us is willing to try for big time television.

After the daily television shows were over we were free to shop or to sightsee, and we took advantage of this. The Danish people did everything in their power to make our congress a successful one. We were entertained at lunch and dinner and special tours were planned for us. On one trip we visited Elsinore Castle where the ghost in *Hamlet* walked. Seeing the Danish countryside is a pleasure which will long be remembered. Of course we thought of our professional responsibilities also and visited schools of nursing and hospitals. Miss Fallon had lunch at the Danish Nursing Council.

One cannot do justice to the Second International Poliomyelitis Congress without a word about the formal opening and the closing banquet. Her Majesty, Queen Ingrid, royal patroness of the congress, attended the opening session. Later she viewed one of our television shows. Mrs. Anderson, the American ambassador to Denmark, also viewed the demonstrations.

The dinner on the closing night was an impressive affair. About nine hundred persons attended, and the service was extremely formal. The highlight came with the dessert. All the room lights were turned off, the orchestra set up a traditional tune, and seventy waiters marched in in single file bearing high on their shoulders huge silver trays. At one end of each tray was an ice cream mold. At the other end was a large cake of ice hollowed out, with a burning candle set in, reflecting through the ice. On top of each cake was a huge letter or figure of carved ice spelling out "Second International Poliomyelitis Congress 1951." This was truly a thrilling ending to a wonderful week spent with our many friends from forty countries.

Many of us remained in Copenhagen to attend the first meeting of the World Confederation of Physical Therapists. This group became an actuality on September 8 when eleven countries adopted the constitution. The executive director of our own American Physical Therapy Association, Mildred Elson, was chosen first president of the World Confederation.

ENID BAILEY, R.N., P.T.
Physical therapy consultant,
VNA of Omaha

Second International Gerontological Congress

THE SECOND International Gerontological Congress met in St. Louis, September 9-14, 1951. This meeting was a continuation of the First International Congress which met in Liege, Belgium, in July 1950 and the First National Conference on Aging, held in Washington, D. C., in August 1950.

There were four concurrent scientific sessions, at which formal papers were presented and symposia and discussions held. Section one was concerned with biology and medicine; section two with sociology, psychology, education, and religion; section three with economics, employment, and welfare; and section four with medical services, hygiene, and housing.

Dr. J. V. Grauman of the United Nations staff said that four distinct definitions of aging are necessary: chronological, physiological, sociological, and psychological. Discussing chronological aspects only, he reported that the increasing proportion of those over sixty-

five years of age was a definite characteristic of weaker nations. Consequently there has been a shift from child dependency to old age dependency. In the Western countries further increases in the "quantity" of old age appear inevitable. Attention must be given to improving the "quality" surrounding advancing years.

In France the percent of those sixty years of age and over is 16.3; in the United States in 1950 it was 11.6 percent. The French situation results from the decline in births originating in the nineteenth century; elsewhere this decline started later. There is a marked distinction between the high percentages of the aged in France, England, Sweden, Germany, and other Western countries and those in the Eastern countries such as Russia due to high mortality rates in East Europe.

All indications point to the continuation of the "aging" trend, with predicted reductions in industrial efficiency, increased difficulty in adopting manpower to new technology, and greater sluggishness in entering new fields of opportunity. Also, increased schooling time will further decrease the size of the working population in the long run.

Although the average span of work life is increasing it is not keeping pace with increases in total life expectation mainly because the age at which persons enter the labor forces is advancing while the retirement age is being lowered. Between 1900 and 1940 the life expectancy of a forty-year-old white male increased from age sixty-eight to seventy, whereas his work-life expectancy decreased from what it had been in 1900.

"The goal of maintaining or even widening the scope of employment opportunities is a feasible one," Dr. Ewan Clague, U. S. commissioner of labor statistics said, "provided that we develop measures for extending the period of work life. Through scientific study of the psychological and physical changes accompanying the process of aging and through realistic analysis of job requirements in relation to these changes we can develop a systematic body of knowledge regarding the employment potential of older persons."

Dr. Ward Crampton of New York suggested the development of a plan for complete examinations to be given at the six epochs of life. This would provide life records which would not only serve the individual but would also advance scientific knowledge. "We have studied diseases rather than lives."

The care of the geriatric patient in his home was discussed. Dr. J. D. Thompson of New York described the home care program of Montefiore Hospital and Dr. L. Udell reported on the intensive home care plan in Philadelphia. Margaret Filson, director of nursing services, and Annie Laurie Baker, Social Service Department, University of Minnesota Hospitals; Helen Kinney, director, Bureau of Nursing, Missouri State Department of Public Health and Welfare; and Miss E. C. Warren of London, England, discussed the team concept. Miss Warren observed that as geriatric knowledge expands the number of team members will probably grow. She said "if the team keeps the patient in the foreground the problem of overlapping or parallel plans for the same patient will largely disappear."

Abbie G. Whidden, director of the Visiting Nurse Association of St. Louis, who represented NOPHN at the congress, tells us that there is much nursing—and in particular public health nursing—has to contribute to this field and urges nurses to become active members of the Gerontological Society.

Abstracts of all the papers appear in the *Journal of Gerontology*, supplement to number 3, volume 6. The *Journal's* address is 660 S. Kingshighway, St. Louis 10, Missouri.

Women In Defense Decade

"Educate a man, and you have educated a lawyer, a doctor, an engineer, a banker, or even a statesman. Educate a woman, someone has said, and you have educated a family. To that we now add: educate a woman and you have educated a family and a community; and if you educate enough women you have educated a nation." Mary Donlon, chairman, New York State Workmen's Compensation Board, and chairman of the Conference on Women in the Defense Decade, in opening the meeting held in New York, September 27-28, 1951, pointed out the basic responsibilities of women to their families and communities.

The conference, sponsored by the American Council on Education, of which NOPHN is a constituent member* was called to define women's responsibilities and opportunities in the period of defense, estimated to last at least ten years. The objective was to make a design "into which all the interests and abilities of women fit and complement one another." Defense was considered in its broadest sense, defense of the free way of life.

The conference participants, including about thirty nurses from all parts of the country, worked in eight sections and considered respectively the following overall topics: The Home—The Source of the Nation's Strength; Citizenship—Defense of Freedom; Health and Welfare—Building America's Strength; The Armed Forces—Women Accept a New Responsibility; Production for Defense and Peace—New Reasons Why Women's Work Is Never Done; Education—Retooling to Meet the Problems We Face; Creative Leisure—Avocations of Busy People; Everyday Economics—The Citizen's Business. Each group prepared a detailed report of its deliberations. There were several points of agreement: that women will serve in the armed forces; that the armed forces alone can never sufficiently defend a civilization such as ours; that women must and will work outside the home not only because of war industries but also because living costs and inflation make it necessary; that the family is already feeling the impact of defense years and will feel it more and more, so it is in need of immediate and specific help; that the family should be well integrated into the community for the sake of all its members.

It was further stated and agreed by the conference that the *primary hope for security lies in the safeguarding of childhood* and that after supplying from their numbers the ones needed for the armed services women's efforts should be directed toward the protection of human relations in the home, the family unit. The family concept must be preserved even in times when the physical family might be disrupted.

Have women abandoned the concept that woman's place is in the home? Elinore Morehouse Herrick, in her paper, America's Women Workers, said that in June 1951 women fourteen years of age and over constituted 52.4 percent of the total civilian population. Of this number more than nineteen million were attached to the labor forces, almost two million of them in agriculture. Women constituted one quarter of the civilian and military employees of the Department of Defense—39,610 serving in the Army, Navy, and Air Force, and 310,740 serving as civilian employees.

* NOPHN delegates to the conference were Florence C. Austin, Esther Lucile Brown, M. Olwen Davies, Virginia M. Dunbar, Marie L. Johnson, Marian G. Randall, and Mrs. Robert S. Wilkinson.

In the last decade the proportion of working wives increased from 14.7 percent to 22.5 percent, the increase occurring mainly in the age group above thirty-five years. This is the age when most women no longer have the responsibility for the care of very young children. In March 1950 about two thirds of all the women in the United States were married and about 25 percent of the married women were in the labor forces, compared to only 17 percent in 1940. The number of women in the labor forces with children under five years of age was 1,121,000 or 10.5 percent of the total.

The homemaker, determined to maintain even the present standards of living in the face of rising costs, will have to give serious consideration to ways of augmenting the family income and at the same time safeguarding family life, strengthening its spiritual and moral values. Barbara Jones, a participant in the same panel as Mrs. Herrick, said, "Many women value the companionship and stimulation of belonging to a working group, the feeling of participating in something important. Housework is isolated, endless, and almost entirely lacking in prestige and opportunities for excellence and recognition. Some women who could make good parttime mothers suffer and deteriorate when obliged to concentrate on housework and motherhood twenty-four hours a day three hundred and sixty-five days a year. Their personal need for a change of occupation runs counter to the general belief that woman's rightful place is in the home, no matter what sort of person she is or wants to be. Many older women with grown children would be better off if they could get jobs."

Woman's place is where she is most needed. If she has children under school age she probably is needed most at home. Mrs. Jones described two approaches to the question of working mothers, the prescriptive and the permissive. In the prescriptive approach society would decide what is best for the women to do and then persuade them to accept the decisions. With the permissive approach women must be given free choice. The implications in the permissive approach are many. Women can't choose to go to work unless they can find jobs adapted to their minimum family responsibilities. Women could take a much larger number of parttime jobs and still fulfill their family responsibilities if industrial management would set up provisions for such work. Mrs. Jones said, "I hope the need of attracting women workers will remain strong enough, long enough, to induce industry to apply its justly vaunted inventiveness to helping women workers cope with the housework. Some good precedents were set during the war: for example, laundries in the plant to which women could bring their wash; grocery shops near the plant, and time off for shopping; free Saturdays so that necessary housework could get caught up and Sunday could be a day of rest. I should like to see even beauty parlors provided.

"Community organizations might also attempt to train household workers, perhaps for specialized jobs, and set up employment pools for various types of housework, taking their cue from the baby-sitting agency."

Mrs. Douglas Horton, who as Mildred McAfee was director of the Waves, said 72,000 women are needed in the next nine months in the armed services. "Many girls and young women may not realize that they can keep a family from being broken up if they volunteer for the armed services, for their acceptance of the responsibility might prevent some young married man from being called up—or back."

In the Health and Welfare Section Marion W. Sheahan presented a paper, The Job of the Professional Team. She said, "The team approach is imperative if the health needs of the people are to be met. This is a process through which a group of people accept the discipline of being organized in unified action to get something done. The essential elements are a common purpose or goal, personnel with agreed upon roles, a differentiation in specialized skills, recognition of the value which each contributing team worker makes according to his role, and an organization structure which provides for interaction between members in planning, policymaking, and activities."

In the same panel Dr. Dorothy B. Ferebee reminded the conference that health is every-

body's business. Every citizen has a responsibility. He must be concerned about what is being done and what is left undone because of lack of funds, legislation, or interest. Women have a special interest in these questions as homemakers and community leaders.

A conference called by the American Council on Education was naturally concerned with the role of education. Everyone recognized that if we are to meet the grave problems we face today, and will continue to face in the next decade, education has a major contribution to make. "But," quoting Professor Esther Lloyd-Jones, "education will not make the contribution that it must unless, as we are asking others to do, it will also make a Herculean effort to be more wise, more courageous, more self critical, more creative, and more energetic in relation to the problems we face." Therein lies the challenge to us all: to be more wise, more courageous, more self critical, more creative, and more energetic.

The American Council on Education plans a series of publications to follow the Conference on Women in the Defense Decade. The first publication, *A New Design for the Defense Decade*, which is Margaret Culkin Banning's summary of the conference, is now ready. This report was presented on the closing day of the conference and won high acclaim. Order from the ACE, 1785 Massachusetts Avenue, N.W., Washington 6, D. C. Single copies, 15 cents; ten copies, $1.25. Rates for larger quantities upon request.

Yale University School of Nursing

(Continued from page 669)

better with her own difficulties and thus improve her work with patients. It is obvious that the nurse needs a better understanding of herself and her own contribution to the recovery of the patient through her attitudes and total personality as well as in her nursing skills. In some schools of nursing the use of a professionally competent counselor has proven of value in meeting this aim. It is conceivable that nondirective conferences with psychologically equipped faculty members would also be of definite benefit to students. Training of the faculty for this kind of interview would be important.

It is a truism to state that students learn good nursing by seeing it practiced. It is essential that students observe and work with other properly oriented professional persons. This presupposes the need for interdisciplinary education, in staff conferences and to a certain extent in formal class work, in order that each one may understand the functions and philosophy of the others.

In the foregoing discussion mention has been made of some of the methods used at Yale University School of Nursing to prepare the student nurse to understand the dynamics of human behavior and the importance of interpersonal relationships. We do not claim that these methods are in every instance perfected, but we repeat them here for the sake of emphasis and because we believe them to be essential tools in nursing education. In brief, they are the use of small discussion classes, patient-centered teaching, correlation of theory and practice, individual patient assignments, evaluation by the student of her experience, and participation as a member of the therapeutic team.

This is one of a number of papers prepared at the request of the Technical Committee on Fact Finding of the Midcentury White House Conference on Children and Youth, 160 Broadway, New York, New York. These papers were reviewed by the committee for use in its work, although conference procedures were not designed to provide for official approval.

Accreditation of Programs in Public Health Nursing

HELEN NAHM, R.N., Ph.D.

The NOPHN *was the first of the national nursing organizations to undertake accreditation. In 1920 this organization published the first list of approved programs in public health nursing. By 1949 thirty-four programs to prepare graduate nurses for beginning positions in public health nursing had been approved and four collegiate basic programs had also been approved for preparing nurses for beginning positions in public health nursing. This article is designed to show the part public health nurses play in current accrediting activities in nursing.*

THE NATIONAL NURSING Accrediting Service came into being in January 1949 as a result of the efforts of the six national nursing organizations. However, interest in the need for unified accreditation had extended over a period of years. As early as 1940 representatives of the National Organization for Public Health Nursing, the National League of Nursing Education, and the Association of Collegiate Schools of Nursing, the agencies which at that time were evaluating educational programs in nursing, met to discuss the unification of accrediting activities. In January 1945, at the request of the National Nursing Planning Committee of the National Nursing Council for War Service, the NLNE called a special meeting to consider the development of a plan for a central accrediting program in nursing. As a result the Committee of Interests to Plan for a Single Professional Accrediting Body was formed in February 1946.

Following the dissolution of the National Nursing Council in January 1948 the six national nursing organizations voted to establish the Joint Committee on the Unification of Accrediting Activities (JCUAA) in order that study of the problem, begun by the Committee of Interests, might be carried further. In June of that year the boards of the six organizations agreed to the appointment under the JCUAA of a Working Group made up of representatives of the ACSN, NLNE, and NOPHN. There was a fourth member of this group whose services were loaned by the Division of Nursing, USPHS. The NOPHN representative on the Working Group was M. Olwen Davies. In addition to formulating a plan for the unification of accrediting activities of the three organizations the group was also concerned with developing a statement of philosophy of accreditation and guiding policies and procedures.

In developing a philosophy of accreditation

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in nursing the Working Group agreed that accreditation should be a flexible process which should stimulate growth and development of an institution; that evaluation should be comprehensive and based upon the total pattern of educational work of an institution; and that it should be related to stated purposes and functions, thus providing for recognition of individuality.

The organizational structure of the National Nursing Accrediting Service (NNAS) is outlined in the Manual of Accrediting Educational Programs in Nursing.* This publication includes also a statement of policy, procedures, and descriptive criteria used in evaluation. Before the manual was published its content was widely circulated among public health nurses employed by official and nonofficial agencies and in public health nursing education. Although NOPHN has transferred its accrediting activities to NNAS it retains responsibility for setting standards for programs designed to prepare nurses for beginning positions in public health nursing as well as for other types of public health nursing education.

Nurses from all over the United States participate in the work of NNAS. Present membership of the JCUAA, which has policymaking functions, includes the president and general director of the NOPHN, Emilie G. Sargent and Anna Fillmore respectively, and, as other NOPHN representatives, Hazel Higbee, Dorothy Wilson, and M. Olwen Davies. Irene Carn and Ella E. McNeil, other public health nurses, are also members of the committee. Miss Higbee is at present chairman of the Public Health Nursing Board of Review. The chairmen of the several boards are members of the Executive Board of Review which coordinates the activities connected with the accrediting processes.

Members and alternates on the boards of review are appointed for a term of three years. To prevent the entire membership changing every three years some of the original members were appointed for one year, some for two years, and the remainder for three years. Present members and alternates of the Public Health Nursing Board of Review in addition to the chairman are Irene Carn, L. Ann Conley, Pearl P. Coulter, Mary M. Dunlop, Marion Murphy, Eleanor Palmquist, Margaret S. Taylor, and Dorothy Wilson. Consultant services from NOPHN have been available to the NNAS staff and also to the boards of review and special committees. The NOPHN general director and associate director for education have acted as ex officio members of important planning committees and groups responsible for the service. All the national nursing organizations have made contributions of funds and services to NNAS. From 1948 to 1950 more than $50,000 was given by these groups, and of this amount NOPHN contributed $15,610.

The Public Health Nursing Board of Review held its first meeting in November 1949. Since then meetings were held in November 1950 and again in November 1951. During the board meetings annual reports of all public health nursing programs are reviewed. Reports of resurveys and surveys of new programs are also studied. In 1950 the Public Health Nursing Board of Review met jointly for the first time with the Collegiate Board of Review to consider reports on collegiate basic programs designed to prepare nurses for beginning positions in public health nursing. This procedure will be continued whenever jurisdiction of the two boards is involved. At present there are thirty-five programs in public health nursing for graduate nurses on the accredited list. Six collegiate basic programs have been approved, and a number of others are making every effort to meet requirements which will make it possible for them also to be so approved. Because NOPHN had for so many years accredited public health nursing programs designed to prepare nurses for beginning positions it was agreed that the Public Health Nursing Board of Review should continue this work, even though another board assumed responsibility for all other programs for graduate nurses. Programs designed to prepare experienced public health nurses for administrative, teaching, supervisory, consultant, and other leadership positions at present come under the jurisdiction of the Postgraduate

* National Nursing Accrediting Service. *Manual of Accrediting Educational Programs in Nursing.* 2 Park Avenue, New York 16. National League of Nursing Education, 1949. 114 p. $4.

Board of Review, as do all other programs for graduate nurses. The latter board does not accredit any single program in isolation, but considers instead the overall competency of a university or college to offer programs for graduate nurses.

In addition to the review of annual and survey reports, members of the Public Health Nursing Board of Review are responsible for the review of applications for accreditation of those new public health nursing programs for graduate nurses which are under the board's jurisdiction and those of collegiate basic programs designed to prepare nurses for beginning positions in public health nursing. Applications are always reviewed by at least two members or alternates on the board of review before a survey is planned. If these two people do not agree a third, and sometimes even a fourth person may be asked to review the application. Because of the cost to the school of a survey by NNAS, board representatives make every effort to review applications carefully and not to recommend a survey until there is reasonable assurance that a program meets criteria believed essential for accreditation. This frequently necessitates delaying the survey and writing to the school for additional information before a decision to recommend a visit is made.

When an application has been approved for a survey the school is immediately notified. Arrangements are then made by the staff at NNAS headquarters to send two qualified nurses who have had experience in the type of program being surveyed to make the visit. The time required varies from four to six days, of which one day is spent reviewing information submitted by the school, and the remainder of the time actually making the visit and writing the report. This is another place where public health nurses make their contribution. Mary C. Connor, Ellen Buell, Hedwig Toelle, Dorothy Carter, Margaret Arnstein, and Mrs. Evelyn Burke have acted as accrediting representatives. Members of the board of review and of JCUAA have also acted in this capacity.

At the time of the survey accrediting representatives make visits to service agencies used for field instruction. This, however, does not constitute accreditation of the public health nursing agency as such. According to the philosophy under which NNAS operates it is considered the responsibility of the school which offers a program in public health nursing to see that its students have satisfactory field experiences. To accredit a field agency in isolation, even though the student program may be of unquestioned merit, would constitute fractional evaluation. It would also make the field agency, rather than the school itself, primarily responsible for seeing that students have a satisfactory teaching program.

Following the survey the report of the visit is sent to the director of the program for corrections. A copy of the corrected report is then sent to each member of the board of review. The decision as to whether a program shall be accredited is made at the time of the meeting of the board of review. The director is strongly urged to be present during the meeting in order that board members may obtain the clearest possible picture of her program.

Any school which thinks that an unfair decision has been made about its program has the right of appeal. To institute appeal procedures the school is asked to notify NNAS within thirty days following notification of the decision of the board of review. The Executive Board of Review hears the appeal.

For the 1949 meeting of the Public Health Nursing Board of Review annual reports were summarized by Mary Dunn and Henrietta Landau. Prior to the 1950 meeting they were reviewed by Lillian Gardiner. Janet M. Walker, associate professor of Public Health Nursing, University of California, Los Angeles, California, spent two months during the summer of 1951 summarizing recent data about the approved public health nursing programs and reviewing the 1950-51 annual reports of these programs. She was present during the November 1951 meeting of the Public Health Nursing Board of Review to present these reports.

Before leaving NNAS headquarters Miss Walker was asked to make comments which might be of value to other public health nurses. Part of her comments follow:

> Universities have a real opportunity as well as a responsibility to present in their annual reports an interpretation of how they meet recommended criteria for faculty, curriculum—including content of field experience—in relation to the stated objectives of their approved programs. I have been impressed with the sincere, objective, unbiased attitudes of persons associated with the National Nursing Accrediting Service in considering reports of approved programs and applications for accreditation. Recommendations to schools are made with a sincere desire to help them move forward toward their goals. I have also been impressed with the extent to which all information is kept in true confidence.

From her experience as chairman of the Public Health Board of Review during the past two years, Hazel Higbee makes the following comment:

> To serve as a member of a board of review is a very real privilege but, like all privileges, it carries many responsibilities. To read and study materials submitted annually by universities and to analyze new applications requires not only much time but also serious consideration. Important and farreaching decisions are to be made and only the most objective, sincere, and honest deliberation of which one is capable is good enough under these conditions. Serving on a board of review is indeed serious business. However, it has its rewards as well as its responsibilities. It is a broadening and deepening experience both professionally and personally.

It is probably no secret to most people who will read this paper that the entire accrediting movement is "under fire" at the present time, particularly in colleges and universities. The National Commission on Accrediting was organized about two years ago by representatives of a number of colleges and universities in protest against the multiplication of accrediting agencies, the control which the agencies attempt to exert over college programs, and the abuses of the entire accrediting movement.

The National Nursing Accrediting Service has been in contact with the National Commission on Accrediting since the latter was first organized and has made every effort to present the necessity for accreditation of nursing programs at this time. Representatives of NNAS met with Chancellor Reuben G. Gustavson, president of the Commission, and Dr. Cloyd Marvin, secretary, in April 1951, and were impressed with their genuine interest in nursing and their earnest desire to understand the problems involved in the upgrading of nursing education programs. However, the fact remains that the continued existence of any accrediting service in the years to come will probably depend on the wisdom of the decisions which are made about school programs and the extent to which accreditation actually stimulates improvements which will result ultimately in a better service to society. Approved programs in public health nursing have made a contribution to the health of this nation and others over a long period of years. It is hoped that the National Nursing Accrediting Service can continue to provide the stimulation toward constant improvement so ably provided for many years by the NOPHN through its Education Committee and its Committee on Accreditation.

NEW BOOKS
And Other Publications

SPEECH HABILITATION IN CEREBRAL PALSY

Marion Cass. New York, Columbia University Press, 1951. 212 p. $3.

There has been a tendency among nurses and nurse physical therapists engaged in the care and treatment of the cerebral palsied child to consider speech education as a somewhat specialized area in which they were not adequately prepared to function. Exercises are regularly given to aid in respiratory control but not enough has been done to correlate these exercises with actual speech formation. In this field, in which very little has been published up to now, Dr. Cass' book offers much that is of practical value for the moderately handicapped child.

The first three chapters give a concise review of the available material on the etiology and treatment of cerebral palsy with a clear explanation of what is known at present concerning the neuroanatomy of its various manifestations. Since these chapters are at once compact and authoritative they constitute in themselves a valuable reference work. They also enable the therapist to relate the new material on speech habilitation to the background with which she is already familiar.

The chapters on speech describe clearly the gradual process, beginning with respiratory control, which leads to the development of understandable speech. The phonetic symbols she uses are familiar to anyone who has studied speech in college and easily mastered by those who have not. All this material is of value to the therapist who is interested in giving complete service to the cerebral palsied child.

Dr. Cass makes clear the psychological factors involved in speech habilitation: the avoidance of fatigue, the adaptation of material to the age level of the child, the value of rapport with the child. An important point, which she emphasizes and which every therapist will want to keep in mind, is that speech development should never be complicated by emphasizing the niceties of pronunciation. Guidance should be centered on the child's basic need for a means of communication with his fellow human beings.

—ELEANOR M. ANDERSON, R.N., *Administrative Assistant, Physical Therapy, Visiting Nurse Association of Brooklyn.*

HOW TO HELP YOUR CHILD IN SCHOOL

Mary and Lawrence K. Frank. New York, The Viking Press, 1950. 368 p. $2.95.

This book is good reading for parents of children of preschool and school age. It describes the growth and development of the child's personality through its many stages and in chronological detail. In reading this book parents will realize that many of their child's behavior patterns that worry them are signs of developing personality traits such as loyalty, independence, social graces, and others. Parents will also appreciate the child's struggle in acquiring emotional stability, intellectual ability, and motor skills. The book contains many practical suggestions and illustrations of how meaningful environment can be provided for the child in his own home. It is important that parents have knowledge of their child's normal growth and development in order to prepare him for his school experience and to be able to help him through all his school years. The child who is given the opportunity to develop a healthy personality should have no trouble in adjusting to the school environment.

The responsibility of both the home and of the school is well covered here. The par-

ents learn what they may expect of the school, and they are made to realize that school cannot provide a cure-all for the maladjusted child. They also learn how important it is for a child to have a home where he is loved, wanted, and where he is allowed to bring his friends. In turn the teacher learns what she may expect of the home.

This book is designed to act as a bridge between the home and the school. The most natural person to transverse this bridge is the public health nurse who has knowledge of the child's normal growth and development. It treats areas of child development that have not been covered before. Public health nurses will find it valuable for it has the answers to so many questions usually asked by parents.

—Anne Prochazka, R.N., *Visiting Nurse Association of Chicago.*

A FEW BUTTONS MISSING

James T. Fisher and Lowell S. Hawley. Philadelphia, J. B. Lippincott Company, 1951. 282 p. $3.50.

This is a delightful informal story of the life and problems of a psychiatrist who is still enjoying himself at eighty-seven. The history of his life experiences reads like a movie scenario of an American young man of enterprise. He concedes that it was not ambition but his father's firm hand and other equally prosaic circumstances that propelled him into veterinary medicine, hence, to human medicine and psychiatry. Yet to him each incident from his earliest recollection seemed to have been woven into his life for a single purpose. They were the primary lessons for a potential psychiatrist. His humor and humility remove the mystery and fear from this "most publicized and least understood branch of medicine." His impressions of Freud, under whom he studied in Vienna, make that gentleman seem more human and, hence, more understandable than many of his biographers have done, while giving full recognition to Freud's contribution to the advancement of psychotherapy.

Dr. Fisher's ideas are sound and simple. His discussion of human needs and behavior and psychological concepts is equally understandable. He believes that when we more fully understand psychiatry, the study of man and his environment and heredity, "we will find its basic truths to be simple, logical, and entirely reasonable—as are all other basic truths on earth."

This book should have value for nurses. It offers a broad view of psychiatry with humor and simplicity to the student. Public health nurses, who work with all kinds of people, will appreciate it as a relief from the usual serious approach, and will recognize old friends in many of the case illustrations, whether human or bovine. While it creates a feeling of familiarity in its approach to psychiatry it is nevertheless a serious book with much knowledge gleaned from an eventful life. "The years teach much which the days never know."

—Ruth Cumings, R.N., *Public Health Nursing Consultant in Mental Health, Westchester County Department of Health, White Plains, New York.*

MATERNAL CARE AND MENTAL HEALTH

John Bowlby. New York, International Documents Service, Columbia University Press, 1951. 179 p. $2.

Once in a great while a book appears which makes us stop and reexamine our professional goals and objectives. Dr. Bowlby was commissioned by the World Health Organization in January 1950 to make a study of the needs of homeless children. His study in France, the Netherlands, Sweden, Switzerland, the United Kingdom, and the United States endeavored to determine the principles underlying mental health of children and the practices by which it may be safeguarded. Such a topic as the mental health of children cannot help but cut across almost every facet of our culture including medicine, nursing, social work, and hospital administration. This study not only questions some of our current nursing practices related to child care, but also with great simplicity and clarity points out the direction toward which we should set our goals to improve the physical and mental health of our children and, hence, our nation.

It is difficult in a brief review to comment on the many important concepts which came

out of this study and their bearings on pediatric, obstetric, and psychiatric nursing, and on problems of institutional planning and organization. I should like, however, to present the author's views regarding one problem with which the public health nurse is particularly concerned, that of prevention of illness.

Mental hygiene programs are needed which would be concerned with "not only treating children, but the giving of psychiatric help to parents, especially the parents of very young children who are in a plastic phase of emotional development and who therefore respond rapidly." Such a program "demands great effort" and "large numbers of skilled workers."

"One question which is likely to be asked is in regard to the position in this program of professional personnel without psychiatric training—physicians, nurses, social workers, and others: Are they to be excluded from participation? On the contrary, only if all these workers are trained can the work be done on the necessary scale. The stage has been reached in preventive medicine in Western countries where disorders springing from infection and malnutrition are, to a large extent, conquered and where health workers are free to give time and energy to mental health . . . but before these workers can be effective, extensive retraining and radical changes in outlook and attitude will be necessary. . . . Such widespread professional training and retraining is today the foremost need both in mental hygiene and the preservation of the family."

"The proper care of children deprived of a normal home life can now be seen to be not merely an act of common humanity, but to be essential for the mental and social welfare of a community. For, when their care is neglected, as happens in every country of the Western world today, they grow up to reproduce themselves. Deprived children, whether in their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid. And just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them."

"Yet, so far, no country has tackled this problem seriously. Even in so-called advanced countries there is a tolerance for conditions of bad mental hygiene in nurseries, institutions, and hospitals to a degree which, if paralleled in the field of physical hygiene, would long since have led to public outcry."

"To those charged with preventive action the present position may be likened to that facing their predecessors responsible for public health a century ago. Theirs was a great opportunity for ridding their countries of dirt-borne diseases; some took it, others remained hypercritical of the evidence and inert."

It is difficult to see how any nurse reading this report could ignore the evidence presented or remain inert. No nurse can read this study without finding some food for thought applicable to her own particular branch of nursing.

—Marion E. Kalkman, R.N., *Instructor in Psychiatric Nursing, University of California.*

EDUCATION

Intergroup Relations in Teacher Education, an analytical study of intergroup education in colleges and schools in the United States: functions, current expressions, and improvements. Lloyd Allen Cook, director. Washington, The American Council on Education. 1951. 271 p. $3.75.

NURSING EDUCATION

A Dynamic Basic Nursing Curriculum. Kathryn W. Cafferty, editor. Washington, The Catholic University of America Press. 1951. 178 p. $2.50.

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Healthy Babies Are Happy Babies. Josephine Hemenway Kenyon and Ruth Kenyon Russell. The New American Library of World Literature, Inc., 501 Madison Avenue, New York 22, N. Y. 1950. 237 p. 35c.

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Introduction to Modern Chemistry. P. C. Gaines, Laurence O. Binder, Jr., and Ray Woodriff. St. Louis, The C. V. Mosby Company. 1951. 576 p. $4.75.

FROM NOPHN HEADQUARTERS

Educators Can Be Informal Too

Report of the meeting of the Collegiate Council on Public Health Nursing Education: a section of the NOPHN

"Informality," "lack of pressure," and "productive" were some of the terms used in the evaluation of the Collegiate Council meeting at Haven Hill Lodge, Milford, Michigan, October 10-13, 1951. Far from being incompatible, council members felt that the first two played a large part in effecting the third.

WHY A WORK CONFERENCE?

Two factors influenced the decision of the Collegiate Council to plan for a work conference in October 1951. For years the group has held traditional meetings complete with speeches, reports, and resolutions. At the 1950 meeting held prior to the APHA meeting in St. Louis the members had attempted through group discussion to arrive at statements of basic agreement on (1) the status of public health nursing as a special area of nursing and (2) trends in nursing education affecting the preparation of the nurse for the public health field. Because of time limitation the group was able only to make a start, but the resulting frustration led to an enthusiastic desire to have an opportunity to continue the discussion. A poll of the Collegiate Council members indicated that very few would be able to attend the 1951 APHA meeting in San Francisco. Thus planning for a work conference in a central location seemed opportune.

PRECONFERENCE PLANNING

Deciding on a place for the conference was simple when we heard about Haven Hill. The million-dollar country estate of the Edsel Ford family is now operated by the Michigan Department of Parks and Recreation for just such work conference groups as ours. (We were preceded by the Governor's Little Hoover Commission and followed by the YWCA.) Located in the heart of a huge state recreation area about forty-five miles north of Detroit, Haven Hill Lodge is atop the highest hill, looking down on treetops and lakes and indescribable autumn colors. In the lodge and its annex there were sleeping, eating, meeting, and playing accommodations for the conference group.

Early last fall preplanning for the conference began. Incidentally, the Collegiate Council's policy of electing officers and choosing a program committee from members who live in the same region of the country does a great deal to facilitate between-meeting activity. As we go into new structure other groups may want to consider this plan. The general areas of discussion had been outlined by the total group in 1950 in St. Louis. However specific problems had to be defined, tentative statements on which future plans were to be based circulated to the membership, and information collected from agencies which assist in public health nursing education. The committee took in its stride such details as setting up a travelers' aid service to get participants from Detroit to Haven Hill—reminding participants that slacks and informal attire would be the order of the day—arranging for the loan of a duplicating machine

from the Detroit Visiting Nurse Association and, what is more, learning how to use it.

Because the problems to be discussed involved collegiate basic programs as well as those for graduate nurses it seemed essential to have the thinking of the ACSN, and invitations were extended to the officers of that organization. The Council of State Directors of Public Health Nursing and selected field agencies were also invited to send representatives so that there could be sharing of opinions and plans with nurses who are actually in the field.

SPECIAL PRECONFERENCE MEETING

For a full day before the conference opened representatives of the six collegiate basic programs which have been accredited as preparing nurses for all types of nursing, including public health nursing, met to discuss their programs. Although each of these educational programs has developed independently it was possible to identify many broad areas of similarity. Out of this meeting came some specific basic curriculum recommendations which will be reported in a future issue of PUBLIC HEALTH NURSING.

THE CONFERENCE ITSELF

Forty-six nurses attended the conference representing twenty-nine universities, the ACSN, the Council of State Directors, and the NOPHN. In addition to the contribution she made as a service agency representative, Emilie Sargent, NOPHN president, was official conference hostess. Conference members said that Mrs. Ford herself could not have made them feel more welcome and at home.

On-the-spot planning and evaluating were done by the service team (a new term to many of us, but much more descriptive than steering committee) composed of group leaders and recorders and members of the executive and program committees.

At two general sessions the participants heard, discussed, and endorsed the report of the preconference meeting, and discussed the developing bachelor's degree programs in "general nursing" or "prespecialization." The remainder of the time was spent in four work groups, which considered the following problems:

1. The need for clarification of such loosely used terms as "integration," "public health nursing as a specialty," "coordinator," et cetera.

2. Determining what responsibilities and competencies are expected of the beginning public health nurse working under direct supervision; defining broad educational experiences to develop these competencies, whether they be accomplished in collegiate basic, traditional public health nursing major, or "general nursing" programs.

3. Realistic objectives of field instruction for the preparation of the beginner who will work under direct supervision. What content or learning experiences should be included? Through what curricular arrangements (that is, sequence, time, et cetera) can objectives of field instruction be most satisfactorily achieved?

4. Determining the responsibility of public health nursing educators in assisting collegiate basic programs working toward accreditation in public health nursing. Many such programs are groping for adequate and appropriate content and method, and for public health nursing faculty. Is consultant service feasible? Could there be a clarification of practices and problems involved in credit transfer between approved and nonapproved programs?

The groups worked long and hard, but time was found for walks through the woods, trips to the orchards where the apples were free, and the kind of informal chatting which is productive of ideas as well as sociability. The Fun Committee (a *must* at any workshop) arranged an early morning bird walk for the hardy souls, and late evening recreation which unveiled an amazing amount of musical and dramatic talent!

OUTCOMES

At summary meetings at the end of the conference real progress was made in reaching agreement in many areas. Confusing terms were defined and these definitions will be given widespread publicity. A method was suggested for developing curricula which will help to produce the competencies needed by the beginning public health nurse. Specific

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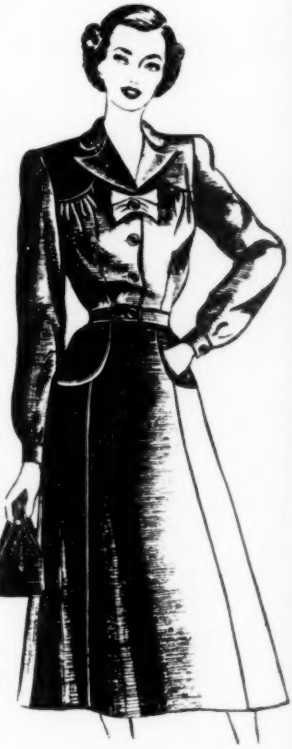

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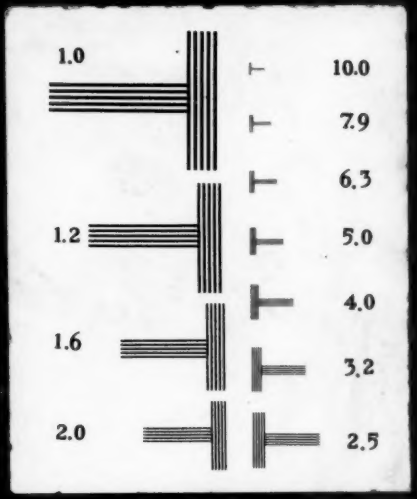

100 MILLIMETERS

INSTRUCTIONS Resolution is expressed in terms of the lines per millimeter recorded by a particular film under specified conditions. Numerals in chart indicate the number of lines per millimeter in adjacent "T-shaped" groupings.

In microfilming, it is necessary to determine the reduction ratio and multiply the number of lines in the chart by this value to find the number of lines recorded by the film. As an aid in determining the reduction ratio, the line above is 100 millimeters in length. Measuring this line in the film image and dividing the length into 100 gives the reduction ratio. Example: the line is 20 mm. long in the film image, and $100/20 = 5$.

Examine "T-shaped" line groupings in the film with microscope, and note the number adjacent to finest lines recorded sharply and distinctly. Multiply this number by the reduction factor to obtain resolving power in lines per millimeter. Example: 7.9 group of lines is clearly recorded while lines in the 10.0 group are not distinctly separated. Reduction ratio is 5, and $7.9 \times 5 = 39.5$ lines per millimeter recorded satisfactorily. $10.0 \times 5 = 50$ lines per millimeter which are not recorded satisfactorily. Under the particular conditions, maximum resolution is between 39.5 and 50 lines per millimeter.

Resolution, as measured on the film, is a test of the entire photographic system, including lens, exposure, processing, and other factors. These rarely utilize maximum resolution of the film. Vibrations during exposure, lack of critical focus, and exposures yielding very dense negatives are to be avoided.